2003-2004

SENATE
HEALTH & HUMAN
RESOURCES

COMMITTEE
MINUTES

SENATE COMMITTEE ON HEALTH AND HUMAN RESOURCES

Senator William R. Purcell, M.D., CoChair
Lorraine Blake 3-5953

Senator Stan Bingham, CoChair
Judy Chriscoe 3-5665

Senator Austin M. Allran, Vice Chair
Carole Walker 3-5876

Senator Joe Sam Queen, Vice Chair
Katie Gooch 3-3460

Senator James Forrester, M.D., Ranking Minority Member
Mary Watson 5-3050

Senator Charlie S. Dannelly
Dee Hodge 3-5955

Senator John A. Garwood
Phyllis Porter 3-5742

Senator Fletcher L. Hartsell, Jr.
Gerry Johnson 3-7223

Senator David W. Hoyle
Penny Williams 3-5734

Senator Jeanne Lucas
Bernie David-Yerumo 3-4599

Senator Vernon Malone
Claudette Howell 3-5880

Senator Stephen M. Metcalf
Angie Whitener 3-5707

Senator Eric M. Reeves
Margie Penven 5-6400

Lorraine R. Blake, Committee Assistant
Judy Chriscoe, Committee Assistant

Linda Attarian, Research Staff
Dianna Jessup, Research Staff

2003-2004 Biennium

Leg. Day: H-102/S-102

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0036=	Womble	REPEAL INVOLUNTARY STERILIZATION.	*SR	Ch. SL 2003-13	03-27-03	04-02-03
H0080	Insko	REPORTS TO MENTAL HEALTH OVERSIGHT COMM.	*SR	Ch. SL 2003-58	03-20-03	05-14-03
H0152	Alexander	PREVENT SIDS/CHILD CARE/INVESTIGATIONS.	*S	Pres. To Gov. 7/11/2003	04-23-03	06-05-03
H0253=	Setzer	CONTINUING CARE RET./ TECH. CHANGES.-AB	*SR	Ch. SL 2003-193	04-03-03	05-27-03
H0278	Culpepper	BD OF CHIROPRACTIC EXAMINERS/EXAMINATION.	*SR	Ch. SL 2003-155	05-05-03	05-22-03
H0318	Warren	CHILDREN WITH DISABILITIES/FEDERAL LAW.-AB	*S	Ref To Com On Health & Human Resources	04-30-03	
H0354=	Insko	AMEND DISABILITY LAWS	*S	Passed 2nd & 3rd Reading	04-23-03	07-20-03
H0461	Alexander	INTERPRETER LICENSURE EFFECTIVE DATE.	SR	Ch. SL 2003-56	03-26-03	05-14-03
H0462=	Alexander	HEALTH INSURANCE/ MARRIAGE & FAMILY THERAPISTS.	SR	Ch. SL 2003-117	04-10-03	05-14-03
H0478=	Rapp	AMBER ALERT.	*SR	Ch. SL 2003-191	04-09-03	05-28-03
H0669	Wright	HOSPITAL LICENSURE/ CRITICAL ACCESS HOSPITAL.	*S	Ref To Com On Health & Human Resources	04-23-03	
H0815	Alexander	DETOX FACILITIES NOT SUBJECT TO CON.	*SR	Ch. SL 2003-390	06-11-03	06-19-03
H0825	Grady	MENINGITIS IMMUNIZATION INFO.	*SR	Ch. SL 2003-194	04-30-03	05-22-03
H0883	Insko	MH REFORM WAIVER.	*SR	Ch. SL 2003-178	05-05-03	05-15-03
H0907=	Alexander	DEAF/HARD OF HEARING ADVISORY COUNCIL.	*SR	Ch. SL 2003-343	05-05-03	05-14-03
$ H0932	**Alexander**	**EST. REG'L. INTERAGENCY COORDINATING COUNCIL.**	***SR**	**Ch. SL 2003-391**	**07-14-03**	**07-18-03**
H0943	Walend	SCHOOLS CAN'T RECOMMEND SOME MEDICATIONS.	*S	Ref To Com On Health & Human Resources	05-01-03	
H1063	McLawhorn	SUMMARY REQUIREMENTS/ CHILD CARE FACILITIES.	*SR	Ch. SL 2003-196	05-01-03	05-27-03
H1118	Alexander	DISPLAY FETAL ALCOHOL SYNDROME WARNING SIGNS.	*SR	Ch. SL 2003-339	05-29-03	06-04-03
H1177	Brubaker	VOLUNTEER M.D.S AT THERAPEUTIC REC. CAMPS.	*SR	Ch. SL 2003-109	05-01-03	05-08-03
$ H1256	**Miller**	**VOLUNTARY DNA DATABASE.**	***S**	**Ref To Com On Health & Human Resources**	**07-16-03**	
H1257	Tolson	AMEND RESPIRATORY CARE PRACTICE ACT/ FEES.	*SR	Ch. SL 2003-384	06-26-03	07-15-03
S0002	R. C. Soles, Jr.	DRIVERS LICENSE MEDICAL CERTIFICATION.	*SR	Ch. SL 2003-14	02-10-03	02-26-03
$ S0204	**A. B Swindell**	**LOCAL LTC PLANNING PILOT PROJECT.**	**S**	**Re-ref Com On Appropriations/ Base Budget**	**02-26-03**	**03-19-03**

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2003-2004 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
S0226=	William R. Purce	UNAUTHORIZED ADMIN. MEDS. BY CHILD CARE FAC.	*S	Pres. To Gov. 7/ 19/2003	02-26-03	03-05-03
S0244	David F. Weinste	RECOGNIZE RETIRED NURSES/FEES.	*SR	Ch. SL 2003-29	02-27-03	03-12-03
S0251	Austin M. Allran	PROHIBIT REBIRTHING.	*SR	Ch. SL 2003-205	02-27-03	03-19-03
$ S0252=	**William R. Purce**	**CAP/DA AUDIT/DHHS REPORT.**	**S**	**Re-ref Com On Appropriations/ Base Budget**	**02-27-03**	**03-19-03**
$ S0253=	**William R. Purce**	**EXPAND SPECIAL ASSISTANCE DEMO PROJECT.**	**S**	**Ref to Health and Human Resources. If fav, re-ref to Appropriations/ Base Budget**	**02-27-03**	
$ S0255	**William R. Purce**	**LTC WORKFORCE IMPROVEMENT PROGRAM.**	**S**	**Ref to Health and Human Resources. If fav, re-ref to Appropriations/ Base Budget**	**02-27-03**	
$ S0262=	**Virginia Foxx**	**MH OVERSIGHT STUDY INTEGRATION OF CARE.**	**S**	**Ref To Com On Rules, Calendar, and Operations of the House**	**03-03-03**	**03-13-03**
S0388	Virginia Foxx	UPDATE CERVICAL CANCER SCREENING COVERAGE.	*SR	Ch. SL 2003-186	03-12-03	04-28-03
S0415=	William R. Purce	HEALTH INSURANCE/ MARRIAGE & FAMILY THERAPISTS.	S	Ref To Com On Health and Human Resources	03-17-03	
S0433	Robert Lee Hollo	4TH SENATORIAL DISTRICT LOCAL ACT-4.	S	Re-ref Com On Health & Human Resources	04-15-03	
$ S0507	**Tony Rand**	**MEDICAID COST SAVING MEASURES.**	**S**	**Re-ref Com On Appropriations/ Base Budget**	**03-24-03**	**04-02-03**
S0519=	William R. Purce	CHILD LEAD POISONING PREVENTION PRGM AMENDS.-AB	*SR	Ch. SL 2003-150	03-24-03	04-14-03
S0522	Tony Rand	BOARD OF NURSING.	*SR	Ch. SL 2003-146	03-25-03	04-07-03
S0533	Hamilton C. Hort	EXEMPTION FROM MH FACILITY LICENSING.	S	Ref To Com On Health & Human Resources	03-25-03	
S0582	William R. Purce	ESTABLISH COMMISSION ON CHILDHOOD OBESITY.	*S	Ref to the Com on Health and, if favorable, to the Com on Rules, Calendar, and Operations of the House	03-31-03	04-30-03
S0602	William R. Purce	CONTROLLED SUBSTANCE/ PHYSICIAN REGISTRATION.	S	Ref to Health & Human Resources. If fav, re-ref to Finance	03-31-03	
S0617=	Jeanne H. Lucas	REPEAL INVOLUNTARY STERILIZATION.	S	Ref To Com On Health & Human Resources	03-31-03	

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2003-2004 Biennium

	Bill	Introducer	Short Title		Latest Action	In Date	Out Date
	S0638	Andrew C. Brock	PARENTAL NOTICE OF HEALTH CARE.	S	Ref To Com On Health & Human Resources	04-01-03	
	S0648	Virginia Foxx	CERVICAL CANCER ELIMINATION TASK FORCE.	*SR	Ch. SL 2003-176	04-01-03	04-21-03
	S0654=	Stephen M. Metca	AMEND MH CONFIDENTIALITY STATUTES.	S	Ref To Com On Health & Human Resources	04-01-03	
	S0657	James Forrester	TANNING SALONS/ RESTRICTIONS ON USE.	S	Re-ref Com On Rules, Calendar, and Operations of the House	04-01-03	04-10-03
$	**S0672=**	**Fletcher L. Hart**	**STRENGTHEN PUBLIC HEALTH INFRASTRUCTURE.**	***S**	**Ref To Com On Rules, Calendar, and Operations of the House**	**04-02-03**	**06-05-03**
$	**S0672=**	**Fletcher L. Hart**	**STRENGTHEN PUBLIC HEALTH INFRASTRUCTURE.**	***S**	**Ref To Com On Rules, Calendar, and Operations of the House**	**06-10-03**	**06-27-03**
	S0704	John H. Kerr III	TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.	*SR	Ch. SL 2003-114	04-02-03	04-21-03
	S0724=	Eleanor Kinnaird	DISCHARGE FROM ADULT CARE HOMES.	S	Ref To Com On Health & Human Resources	04-03-03	
	S0741=	Jeanne H. Lucas	MEDICAL BOARD MEMBERSHIP.	S	Ref To Com On Health & Human Resources	04-03-03	
	[redacted]50	Stephen M. Metca	LCSW/QUALIFIED PROFESSIONAL FOR MH COMMITMT.	S	Ref To Com On Health & Human Resources	04-03-03	
	S0852	Stephen M. Metca	ORGAN DONOR ORG'S./ ACCESS TO DMV RECORDS.	*S	Ref To Com On Finance	04-03-03	06-05-03
	S0876	William R. Purce	CONTROLLED SUBSTANCE/ PHYSICIAN REGISTRATION.	*SR	Ch. SL 2003-335	04-03-03	04-21-03
	S0880=	Tom Apodaca	UNC/ADD NONSMOKING AREAS.	S	Ref To Com On Health & Human Resources	04-03-03	
	S0897=	Joe Sam Queen	MEDICAID PRIOR AUTHORIZATION.	*SR	Ch. SL 2003-179	04-03-03	04-21-03
$	**S0926**	**Tony Rand**	**CLARIFY GROUP HOMES LICENSURE & LEA REIMBURS.**	***SR**	**Ch. SL 2003-294**	**04-03-03**	**04-21-03**
	S0942=	Austin M. Allran	ABORTION/EXTEND CONSCIENCE PROTECTION.	S	Ref To Com On Health & Human Resources	04-03-03	
	S0964=	A. B Swindell	DEAF/HARD OF HEARING ADVISORY COUNCIL.	S	Ref To Com On Health & Human Resources	04-03-03	
	S0975	Katie G. Dorsett	ACCESSIBLE ELECTRONIC INFO ACT/BLIND/ DISAB'D.	*S	Re-ref Com On Appropriations/ Base Budget	04-29-03	04-30-03
	S0986	Eric Miller Reev	STUDENTS WITH	S	Re-ref Com On	04-03-03	04-23-03

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2003-2004 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		DISABILITIES/MEDICAID.		Appropriations/ Base Budget		
S1006	Robert Lee Hollo	REFORM MEDICAL BOARD.	S	Ref To Com On Health & Human Resources	04-03-03	
S1016	Philip E. Berger	NURSING HOME/ MEDICATION ERRORS.	*SR	Ch. SL 2003-393	04-03-03	04-30-03

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
February 26, 2003 at 12:00 Noon
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

S.B. 2, Drivers License Medical Certification

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, February 26, 2003
12:00 Noon
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 12:00 P.M. on Wednesday, February 26, 2003 in Room 544 of the Legislative Office Building. Nine members were present. Senator William R. Purcell, Co-Chair presided.

Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages. Senator Soles was introduced to present his bill, *Drivers License/Medical Certification* to the committee. Senator Soles introduced a Proposed Committee Substitute to the original bill, and Senator Reeves moved that it be adopted for purposes of discussion.

Senator Soles explained the intent of the bill and the proposed committee substitute. He introduced Ms. Sharon Matthews of the Department of Motor Vehicles. Senator Forrester asked if a Physician Assistant would be allowed to sign the certificate allowing a license to be issued. Ms. Attarian cited a North Carolina statute stating that a Physician Assistant could perform the examination. Senator Dannelly asked if the Physician Assistant is authorized to sign the certificate. Ms. Attarian responded that the form can be signed by a Nurse Practitioner or a Physician Assistant. Senator Dannelly moved for a favorable report as to the committee substitute, unfavorable to the bill.

The meeting adjourned at 12:20 P.M.

William R. Purcell
Senator William R. Purcell, CoChair

Stan Bingham
Senator Stan Bingham, CoChair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH AND HUMAN RESOURCES COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, February 26, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **2** Drivers License Medical Certification.

Draft Number:	PCS15071
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 2

Short Title:	Drivers License Medical Certification.	(Public)
Sponsors:	Senator Soles.	
Referred to:	Health and Human Resources.	

February 10, 2003

A BILL TO BE ENTITLED

AN ACT TO ALLOW CERTAIN APPLICANTS FOR DRIVERS LICENSES TO SUBMIT MEDICAL CERTIFICATES FROM OUT-OF-STATE PHYSICIANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-9(g)(2) reads as rewritten:

"(g) The Division may issue a driver's license to any applicant covered by subsection (e) of this section under the following conditions:

...

(2) The Division shall not issue a license pursuant to this section unless the applicant has submitted to a physical examination by a physician or surgeon duly licensed to practice medicine in this State and unless such examining physician or surgeon has completed and signed the certificate required by subdivision (1). <u>If the applicant is a resident of a county that borders another state, then the applicant may submit a certificate completed and signed by a physician duly licensed to practice in the bordering state and practicing in a county or independent city adjacent to North Carolina.</u> Such certificate shall be devised by the Commissioner with the advice of qualified experts in the field of diagnosing and treating physical and mental disorders as he may select to assist him and shall be designed to elicit the maximum medical information necessary to aid in determining whether or not it would be a hazard to public safety to permit the applicant to operate a motor vehicle, including, if such is the fact, the examining physician's statement that the applicant is under medication and treatment and that such person's physical or mental disability is controlled. The certificate shall contain a waiver of privilege and the recommendation of the examining physician to the Commissioner as to whether a license should be issued to the applicant."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 2
PROPOSED COMMITTEE SUBSTITUTE S2-PCS15071-RM-1

Short Title: Drivers License Medical Certification. (Public)

Sponsors:

Referred to:

February 10, 2003

A BILL TO BE ENTITLED

AN ACT TO ALLOW CERTAIN APPLICANTS FOR DRIVERS LICENSES TO SUBMIT MEDICAL CERTIFICATES FROM OUT-OF-STATE PHYSICIANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-9(g)(2) reads as rewritten:

"(g) The Division may issue a driver's license to any applicant covered by subsection (e) of this section under the following conditions:

...

(2) The Division shall not issue a license pursuant to this section unless the applicant has submitted to a physical examination by a physician or surgeon duly licensed to practice medicine ~~in this State~~ and unless such examining physician or surgeon has completed and signed the certificate required by subdivision (1). Such certificate shall be devised by the Commissioner with the advice of qualified experts in the field of diagnosing and treating physical and mental disorders as he may select to assist him and shall be designed to elicit the maximum medical information necessary to aid in determining whether or not it would be a hazard to public safety to permit the applicant to operate a motor vehicle, including, if such is the fact, the examining physician's statement that the applicant is under medication and treatment and that such person's physical or mental disability is controlled. The certificate shall contain a waiver of privilege and the recommendation of the examining physician to the Commissioner as to whether a license should be issued to the applicant."

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

SENATE BILL 2:
Drivers License Medical Certification

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Sen. Soles
Date:	February 26, 2003	**Summary by:**	Linda Attarian Committee Counsel
Version:	Introduced		

SUMMARY: Senate Bill 2 amends the law that authorizes the Division of Motor Vehicles (DMV) to conditionally issue drivers license to applicants who are afflicted with or suffer from a physical or mental disability or disease that may impair their ability to safely operate a motor vehicle. The statute is amended to allow the DMV to issue the license upon the applicant's submission of a signed statement from a physician licensed in this State or in a bordering state if the applicant is a resident of a county that borders another state, and the out-of-state physician's practice is located in a county (or in Virginia, an "independent city") adjacent to North Carolina. The bill deletes the current restriction that the physician must be licensed to practice in North Carolina. The act is effective when it becomes law.

CURRENT LAW: G.S. 20-9 restricts the authority of the Division of Motor Vehicles to issue drivers licenses to certain applicants. The restriction that is relevant to the proposed legislation is G.S. 20-9(e), which prohibits DMV from issuing a drivers license to anyone who is afflicted with or suffering from a physical or mental disability or disease that may prevent the person from exercising control over a motor vehicle on the highways or to understand highway warning or direction signs. However, the law provides an exception if DMV is able to determine that, despite the disability, the applicant does not pose a safety hazard. DMV must make this determination in part, on their reliance on a signed certificate stating that the applicant's physical or mental disability is controlled by medication and treatment. The certifying physician must be licensed to practice medicine in North Carolina.

BILL ANALYSIS: The bill will delete the requirement that the certifying physician hold a license to practice in North Carolina and replace it with broader language to allow DMV to consider certificates signed by physicians licensed to practice in bordering states. The applicant must reside in a North Carolina county that borders the state in which the out-of-state physician is licensed to practice. And the out-of-state examining physician must be practicing in a county or independent city (applies only to Virginia) that is adjacent to North Carolina. Thus, the bill will accommodate persons who live in counties bordering other states and whose examining physician practices in a county adjacent to North Carolina.

BACKGROUND: North Carolina statutes and rules contain various provisions requiring a physical examination to be conducted by a licensed physician for a variety of purposes. Only a few allow the physician to be licensed in states other than North Carolina. An example of a statute that does is G.S. 97-27(b), which governs workers compensation cases in which there is a question as to the percentage of permanent disability suffered by an employee and the employee is dissatisfied with the examination conducted by the physician designated by the Industrial Commission. Under this subsection, the employee is allowed to have another medical examination, and it may be conducted by a "*duly qualified physician or surgeon licensed and practicing in North Carolina or by a duly qualified physician or surgeon licensed to practice in South Carolina, Georgia, Virginia and Tennessee*" provided that the physician has been approved by the NC Industrial Commission.

"Independent cities": The State of Virginia has counties *and* independent cities. There are 41 independent ities and 95 counties. These cities have the same authority as counties.

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **February 26, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sharon Matthews	DOT-DMV
Susan M. Stewart	DOT - DMV
C.P. Dowell	NCDOT/Treasurer
Brad Overcash	Intern for Sen. P. Metcalf
[illegible]	GOO office
[signature]	UHS
[signature]	NC - NOW
Jan Allen	NC - NOW
Robin Davis	NC - NOW
Sarah Karges	NARAL Pro-Choice America in NC
Paige Dixon	Planned Parenthood Central NC
[signature] ANN [illegible]	NCANP OWLS
[signature]	NCNS

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **February 26, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Lowe	NCMHP
Ken Melton	Alley Associates, Inc.
John Bowdish	Master of the Universe
Steve Mitchell	Novartis

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE

March 5, 2003 at 11:00
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

SB 226, Unauthorized Admin. Meds. By Child Care Fac.

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES
Wednesday, March 5, 2003
11:00 a.m.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, March 5, 2003, in Room 544 of the Legislative Office Building. Thirteen members of the committee were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator William R. Purcell, Co-Chair, welcomed committee members present. There were no pages.

Senator Bingham recognized Senator Purcell the sponsor of Senate Bill 226: *Unauthorized Administration of Medication by Child Care Facilities* to explain the bill. Senator Purcell brought forth a Proposed Committee Substitute. In order to act on a Proposed Committee Substitute the members must have a copy twenty-four hours before the meeting. In this case the committee substitute was printed less than twenty-four hours before the meeting, so the motion before the board was to hear the Proposed Committee Substitute. The motion carried unanimously.

Rob Johnson, District Attorney from Alamance County, who requested this bill, which came about after a child died in Alamance County spoke in favor of the bill. He stated that his client, Kaitlyn Shevlin's parents, who also attended the meeting, lost their child in a day care. The death was ruled Sudden Infant Death Syndrome, however law enforcement investigations suspect the day-care provider gave the child a generic form of the medicine Benadryl to make the child sleep. This was the second child to die in the day care. There are other cities and states that have experienced the same sad incidents. SB 226 would change the punishment to a Class II Felony and if an injury is involved, it would be punishable as a Class F Felony verses a Misdemeanor.

Senator Lucas asked, since there are Class F Felonies and Misdemeanors in the bill, if it is passed will it leave this committee and go to another committee. She asked to speak to staff about the sentencing. Staff Linda Attarian stated it is not necessary or required to be referred to a Judiciary Committee, but if this Committee prefers, then that is okay.

Senator Dannley moves at the appropriate time for a favorable report.

Senator Forrestry stated if it is going to JI or JII it should have incarceration notes or fiscal notes. Senator Purcell stated they have a fiscal note (attached).

Staff Linda Attarian, pointed out that subsection A makes it unlawful for the unauthorized administration of medications in a childcare facility, licensed or unlicensed. Currently the regulations only apply to licensed facilities. Lines 13 & 14 specifies that the authorization shall be in accordance with the rules adopted by the North Carolina Child Care Commission. This is to bring into play the regulations that are already familiar to the childcare facilities.

Senator Reeves, ask about the authorization, is it for a specific authorization for a specify medication and specific time. Sen. Purcell thinks that is up to the parent and it has to be renewed every six months. It is a one-dose permission. Staff Linda Attarian, pointed out that in the bill analysis (attached) there is a general overview at the bottom of the page, which gives current laws.

Senator Lucas made the motion to refer SB 226 to JII.

The motion before the committee, unfavorable report as to the original bill, but favorable report as to the Proposed Committee Substitute Bill with a recommendation that the bill be re-referred to JII. The motion carried unanimously.

Senator Bingham said it would be re-referred to JII but there were a couple of folks attending the meeting who would like to speak. Roslyn Savitt, NC Child Care Coalition, spoke in favor of the bill.

Senator Bingham expressed heart-felt sympathy to the family and friends of Kaitlyn on behalf of the committee and himself.

The meeting adjourned at 11:45 a. m.

Stan Bingham
Senator Stan Bingham, Co-Chair

William R. Purcell
Senator William R. Purcell, Co-Chair

Judy F. Chriscoe
Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH AND HUMAN RESOURCES COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, March 05, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **226** Unauthorized Admin. Meds. By Child Care Fac.

Draft Number:	PCS65097
Sequential Referral:	None
Recommended Referral:	Judiciary II
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 226

Short Title:	Unauthorized Admin. Meds. by Child Care Fac.	(Public)
Sponsors:	Senators Purcell, Gulley; Albertson, Allran, Bingham, Blake, Carpenter, Clodfelter, Dalton, Dannelly, Dorsett, Forrester, Foxx, Garrou, Malone, Moore, Sloan, and Weinstein.	
Referred to:	Health and Human Resources.	

February 26, 2003

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE ADMINISTRATION OF MEDICATION TO A CHILD IN A LICENSED OR UNLICENSED CHILD CARE FACILITY WITHOUT PROPER AUTHORIZATION FROM THE CHILD'S PARENT OR GUARDIAN OR A BONA FIDE MEDICAL CARE PROVIDER.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "Kaitlyn's Law".

SECTION 2. Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-102.1A. Unauthorized administration of medication.**

It is unlawful for an employee, owner, or operator of a licensed or unlicensed child care facility to administer any type of medication to a child attending the child care facility without first obtaining written or oral authorization from the child's parent or guardian or a bona fide medical care provider. Any person who violates this section is guilty of a Class H felony. For purposes of this section, the term 'bona fide medical care provider' is limited to medical doctors, physician's assistants, registered nurses, or licensed practical nurses, emergency medical technicians, and paramedics."

SECTION 3. This act becomes effective December 1, 2003, and applies to offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 226
PROPOSED COMMITTEE SUBSTITUTE S226-PCS65097-RM-2

Short Title: Unauthorized Admin. Meds. by Child Care Fac. (Public)

Sponsors:

Referred to:

February 26, 2003

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE ADMINISTRATION OF MEDICATION TO A CHILD IN A LICENSED OR UNLICENSED CHILD CARE FACILITY WITHOUT PROPER AUTHORIZATION FROM THE CHILD'S PARENT OR GUARDIAN.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "Kaitlyn's Law".

SECTION 2. Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-102.1A. Unauthorized administration of medication.**

(a) It is unlawful for an employee, owner, household member, volunteer, or operator of a licensed or unlicensed child care facility to administer prescription or over-the-counter medications to a child attending the child care facility without written authorization from the child's parent or guardian in accordance with rules adopted by the North Carolina Child Care Commission.

(b) In the event of an emergency medical condition and the child's parent or guardian is unavailable, it shall not be unlawful to administer medication to a child attending the child care facility without written authorization from the child's parent or guardian if the medication is administered with the authorization and in accordance with instructions from a bona fide medical care provider. For purposes of this subsection, the following definitions apply:

(1) A bona fide medical care provider means an individual who is licensed, certified, or otherwise authorized to prescribe the medication.

(2) An emergency medical condition means circumstances where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

(c) A violation of this section that results in serious injury to the child shall be punished as a Class F felony.

(d) Any other violation of this section shall be punished as a Class H felony.

SECTION 3. This act becomes effective December 1, 2003, and applies to offenses committed on or after that date.

SENATE BILL 226: Unauthorized Administration of Medication by Child Care Facilities

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Sen. William Purcell
Date:	March 4, 2003	**Summary by:**	Linda Attarian Committee Counsel
Version:	Introduced/PCS		

SUMMARY: ***The Introduced Version of Senate Bill 226 would make the unauthorized administration of medication to a child attending a licensed or unlicensed child care facility by an employee, owner or operator of the child care facility a Class H felony. The bill is effective December 1, 2003 and applies to offenses committed on or after that date.***

The proposed committee substitute (PCS) would make the administration of medication to a child attending a licensed or an unlicensed child care facility without written authorization from the child's parent or guardian unlawful. A violation of the statute by an employee, owner, household member, volunteer or operator of a child care facility is a Class H felony, except that a violation that results in serious injury to the child would be punishable as a Class F felony. The PCS provides an exception for circumstances in which an emergency medical condition presents itself and the child's parent is unavailable. In this situation, medication may be lawfully administered without the parent's written authorization if the medication is administered with the authorization of a bona fide medical care provider and in accordance with the provider's instructions. The PCS does not change the bill's effective date.

CURRENT LAW: G.S. 110-91(9) directs the NC Child Care Commission to adopt rules to establish minimum requirements for record keeping for child care facilities. The scope of this authority includes records regarding authorization to administer medications. Rules adopted by the Commission in 1986, and amended in 1996, 1998, and 2001 provide for the following with respect to the administration of medications in child care facilities:

- No drug or medication may be administered to any child in a licensed child care facility without specific written instructions from the child's parent or guardian.
- No drug or medication may be administered for a non-medical purpose, including inducing sleep.
- Prescribed medication may be administered only with parent's written authorization and the medication must be in its original container with proper labeling, including directions for dosage, or the parent must provide written instructions that must be signed and dated by the prescribing physician or health professional.
- Over-the-counter medication may be administered only with the parent's written authorization and only in accordance with written dosage instructions of the parent, physician or other authorized health professional.

- A parent may provide written authorization that is valid for up to six months to authorize the administration of medication to treat the symptoms of asthma and allergic reactions, and up to one year to administer sunscreen and over-the-counter diapering creams. The authorization must be specific as to the symptoms or conditions for which the medication may be administered.
- A parent may provide written authorization for the administration of a one-time, weight appropriate dose of acetaminophen in the event the child has a fever and the parent cannot be reached.

Enforcement Authority:

Administrative penalties: G.S. 110-102.2 authorizes the Secretary of DHHS to impose one or more of the following against a licensee:

- Issue a written warning and a request for compliance;
- Issue an official reprimand;
- Place a licensee on probation;
- Suspend the license for a period not to exceed one year; and
- Permanently revoke the license.

Civil penalties: G.S. 110-103.1 authorizes the Secretary to impose a civil penalty, not to exceed $1,000 for each violation documented on any given date, against an operator of a child care facility who violates NC law governing child care facilities. In determining the amount of the penalty, the Secretary must consider the threat of or extent of harm to children and the consistency of violations.

BILL ANALYSIS:

The Introduced Version of Senate Bill 226 would make it unlawful for an employee, owner or operator of a child care center or family child care home, irrespective of whether the facility is licensed, to administer any medication, prescription or over-the-counter, to a child attending the facility unless the employee, owner or operator first obtains written or oral authorization from the child's parent or guardian or from a "bona fide medical care provider". A violation of the statute is a Class H felony.

The Introduced Version would change the current law governing the administration of medications as follows:

- Allows a health care provider (as defined in the bill) to authorize the administration of medication; Current rules limit this authority to parents and guardians.
- Allows for oral authorizations in addition to written authorizations; Current rules require written.
- Applies the prohibition against administering medications without prior authorization to non-licensed facilities as well as licensed facilities; Current rules only apply to licensees;
- Imposes a Class H felony penalty for violating the statute;
    - It is not necessary to prove an intent to harm the child.
    - Current rules limits the Secretary of DHHS enforcement power to administrative and civil penalties.

The Proposed Committee Substitute makes the following changes to the Introduced Version:

- Expands the applicability of the statute to include household members of a family care facility provider and volunteers.
- Deletes provision allowing for oral authorization. The PCS conforms to current regulations that require written authorization.
- Provides for an enhanced penalty for violations resulting in serious injury to a child.
- Provides an exception for emergency medical conditions when the child's parent is unavailable.

Class H felony: Punishable by an absolute minimum of 4 months Community Service Punishment and an absolute maximum of 30 months Active Punishment, depending on prior convictions and aggravating factors.

Class F felony: Punishable by an absolute minimum of 10 months Intermediate Punishment (e.g. supervised probation) or Active Punishment to an absolute maximum of 59 months of Active Punishment, depending on prior convictions and aggravating factors.

BACKGROUND:

Inspiration for the legislation:

Senate Bill 226 is a recommendation of the NC Child Fatality Task Force. The Task Force was inspired to recommend the bill after hearing the story of Kaitlyn Shevlin, a 5-month-old who died in an unlicensed day-care home in Alamance County in 2001. According to Mr. Rob Johnson, District Attorney for Alamance County, although medical examiners could not find a definitive cause of death and as a result ruled that the child died from Sudden Infant Death Syndrome, law enforcement investigators suspect her day-care provider gave the child a generic form of the medicine Benadryl to make her sleepy. The day care provider was unlicensed and had numerous complaints of child neglect filed against her in the 20 years she operated her unlicensed facility. She was convicted of misdemeanor charges of child abuse and neglect served four months in prison.

Relevant Definitions (cut and pasted from G.S. 110-86):

- **Child care**. - A program or arrangement where three or more children less than 13 years old, who do not reside where the care is provided, receive care on a regular basis of at least once per week for more than four hours but less than 24 hours per day from persons other than their guardians or full-time custodians, or from persons not related to them by birth, marriage, or adoption.

- **Child care facility**. - Includes child care centers, family child care homes, and any other child care arrangement not excluded by G.S. 110-86(2), that provides child care, regardless of the time of day, wherever operated, and whether or not operated for profit.

a. **A child care center** is an arrangement where, at any one time, there are three or more preschool-age children or nine or more school-age children receiving child care.

b. **A family child care home** is a child care arrangement located in a residence where, at any one time, more than two children, but less than nine children, receive child care.

- **Child care does not include the following**:

a. Arrangements operated in the home of any child receiving care if all of the children in care are related to each other and no more than two additional children are in care;

b. Recreational programs operated for less than four consecutive months in a year;

c. Specialized activities or instruction such as athletics, dance, art, music lessons, horseback riding, gymnastics, or organized clubs for children, such as Boy Scouts, Girl Scouts, 4-H groups, or boys and girls clubs;

d. Drop-in or short-term care provided while parents participate in activities that are not employment related and where the parents are on the premises or otherwise easily accessible, such as drop-in or short-term care provided in health spas, bowling alleys, shopping malls, resort hotels, or churches;

e. Public schools;

f. Nonpublic schools described in Part 2 of Article 39 of Chapter 115C of the General Statutes that are accredited by the Southern Association of Colleges and Schools and that operate a child care facility as defined in subdivision (3) of this section for less than six and one-half hours per day either on or off the school site;

g. Bible schools conducted during vacation periods;

h. Care provided by facilities licensed under Article 2 of Chapter 122C of the General Statutes;

i. Cooperative arrangements among parents to provide care for their own children as a convenience rather than for employment; and

j. Any child care program or arrangement consisting of two or more separate components, each of which operates for four hours or less per day with different children attending each component.

- "**Household member**" to mean: "member of the household in a family child care home or nonlicensed child care home and is over 15 years old and is present when children are in care." (G.S. 110-90.2)
- "**Volunteer**" to mean "a person who works in a child care facility and is not monetarily compensated by the facility" (NCAC 10-3U.0102).

SENATE BILL 226: Unauthorized Administration of Medication by Child Care Facilities

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Sen. William Purcell
		Summary by:	Linda Attarian Committee Counsel
Date:	March 4, 2003		
Version:	Introduced		

*SUMMARY: **Senate Bill 226 would make the unauthorized administration of medication to a child attending a licensed or unlicensed child care facility by an employee, owner or operator of the child care facility a Class H felony.***

CURRENT LAW: G.S. 110-91(1) directs the NC Commission for Health Services to adopt rules to establish minimum requirements for health care procedures for child care facilities. Rules adopted by the Commission in 1986, and amended in 1996, 1998, and 2001 provide for the following with respect to the administration of medications in child care facilities:

- No drug or medication may be administered to any child in a licensed child care facility without specific written instructions from the child's parent, a physician, or other authorized health professional.
- No drug or medication may be administered for a non-medical purpose, including inducing sleep.
- Prescribed medication may be administered only with parent's written authorization and the medication must be in its original container with proper labeling, including directions for dosage, or the parent must provide written instructions that must be signed and dated by the prescribing physician or health professional.
- Over-the-counter medication may be administered only with written authorization and only in accordance with written dosage instructions of the parent, physician or other authorized health professional.
- A parent may provide written authorization that is valid for up to six months to authorize the administration of medication to treat the symptoms of asthma and allergic reactions, and up to one year to administer sunscreen and over-the-counter diapering creams. The authorization must be specific as to the symptoms or conditions for which the medication may be administered.
- A parent may provide written authorization for the administration of a one-time, weight appropriate dose of acetaminophen in the event the child has a fever and the parent cannot be reached.

Enforcement Authority:

Administrative penalties: G.S. 110-102.2 authorizes the Secretary of DHHS to impose one or more of the following against a licensee:

- Issue a written warning and a request for compliance;

- Issue an official reprimand;
- Place a licensee on probation;
- Suspend the license for a period not to exceed one year; and
- Permanently revoke the license.

Civil penalties: G.S. 110-103.1 authorizes the Secretary to impose a civil penalty, not to exceed $1,000 for each violation documented on any given date, against an operator of a child care facility who violates NC law governing child care facilities. In determining the amount of the penalty, the Secretary must consider the threat of or extent of harm to children and the consistency of violations.

BILL ANALYSIS: Senate Bill 226 would make it unlawful for an employee, owner or operator of a child care center or family child care home, irrespective of whether the facility is licensed, to administer any medication, prescription or over-the-counter, to a child attending the facility unless the employee, owner or operator first obtains written or oral authorization from the child's parent or guardian or from a "bona fide medical care provider".

Senate Bill 226 would change the current law governing the administration of medications as follows:

- Allows for oral authorizations to administer medications in addition to written authorizations (current law limits authorization to written);
- Defines the types of health care professionals who may authorize the administration of medications. Current law specifies that authorization may be obtained from an "authorized health care professional"; the bill limits this authorization from a "bona fide medical care provider" and defines that group to include only MD's, physician's assistants, RN's, LPNs, EMTs, and paramedics'
- Applies the prohibition against administering medications without prior authorization to non-licensed facilities as well as licensed facilities. Current law only applies to licensees.
- Adds a criminal penalty for violating the statute. Under the bill, any person who violates the provision is guilty of a Class H felony, which is punishable by an absolute minimum of 4 months Community Service punishment and an absolute maximum of 30 months Active punishment. The bill does not require that the violator intended to harm the child. Actual punishment level is determined by the offender's record of prior convictions. Current law authorizes the Secretary to impose limited administrative and civil penalties.

BACKGROUND:

Inspiration for the legislation:

Senate Bill 226 is a recommendation of the NC Child Fatality Task Force. The Task Force was inspired to recommend the bill after hearing the story of Kaitlyn Shevlin, a 5-month-old who died in an unlicensed day-care home in Alamance County in 2001. According to Mr. Rob Johnson, District Attorney for Alamance County, although medical examiners could not find a definitive cause of death and as a result ruled that the child died from Sudden Infant Death Syndrome, law enforcement investigators suspect her day-care provider gave the child a generic form of the medicine Benadryl to make her sleepy. The day care provider was unlicensed and had numerous complaints of child neglect filed against her in the 20

years she operated her unlicensed facility. She was convicted of misdemeanor charges of child abuse and neglect served four months in prison.

Definitions (cut and pasted from G.S. 110-86):

Child care. - A program or arrangement where three or more children less than 13 years old, who do not reside where the care is provided, receive care on a regular basis of at least once per week for more than four hours but less than 24 hours per day from persons other than their guardians or full-time custodians, or from persons not related to them by birth, marriage, or adoption.

Child care facility. - Includes child care centers, family child care homes, and any other child care arrangement not excluded by G.S. 110-86(2), that provides child care, regardless of the time of day, wherever operated, and whether or not operated for profit.

a. **A child care center** is an arrangement where, at any one time, there are three or more preschool-age children or nine or more school-age children receiving child care.

b. **A family child care home** is a child care arrangement located in a residence where, at any one time, more than two children, but less than nine children, receive child care.

Child care does not include the following:

a. Arrangements operated in the home of any child receiving care if all of the children in care are related to each other and no more than two additional children are in care;

b. Recreational programs operated for less than four consecutive months in a year;

c. Specialized activities or instruction such as athletics, dance, art, music lessons, horseback riding, gymnastics, or organized clubs for children, such as Boy Scouts, Girl Scouts, 4-H groups, or boys and girls clubs;

d. Drop-in or short-term care provided while parents participate in activities that are not employment related and where the parents are on the premises or otherwise easily accessible, such as drop-in or short-term care provided in health spas, bowling alleys, shopping malls, resort hotels, or churches;

e. Public schools;

f. Nonpublic schools described in Part 2 of Article 39 of Chapter 115C of the General Statutes that are accredited by the Southern Association of Colleges and Schools and that operate a child care facility as defined in subdivision (3) of this section for less than six and one-half hours per day either on or off the school site;

g. Bible schools conducted during vacation periods;

h. Care provided by facilities licensed under Article 2 of Chapter 122C of the General Statutes;

i. Cooperative arrangements among parents to provide care for their own children as a convenience rather than for employment; and

j. Any child care program or arrangement consisting of two or more separate components, each of which operates for four hours or less per day with different children attending each component.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 226
PROPOSED COMMITTEE SUBSTITUTE S226-CSRM-2 [v.2]

3/4/2003 10:06:49 AM

Short Title: Unauthorized Admin. Meds. by Child Care Fac. (Public)

Sponsors:

Referred to:

February 26, 2003

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE ADMINISTRATION OF MEDICATION TO A CHILD IN A LICENSED OR UNLICENSED CHILD CARE FACILITY WITHOUT PROPER AUTHORIZATION FROM THE CHILD'S PARENT OR GUARDIAN OR A BONA FIDE MEDICAL CARE PROVIDER.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "Kaitlyn's Law".

SECTION 2. Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-102.1A. Unauthorized administration of medication.**

(a) It is unlawful for any person who has responsibility for the care of a child in a licensed or unlicensed child care facility, including an employee, owner, or operator, to administer prescription or over-the-counter medications to a child attending the child care facility without written authorization from the child's parent or guardian or a bona fide medical care provider. For purposes of this section, the term 'bona fide medical care provider' is limited to medical doctors, physician's assistants, registered nurses, or licensed practical nurses, emergency medical technicians, and paramedics.

(b) A violation of this section that results in serious injury to the child shall be punished as a Class F felony.

(c) A violation of this section that was committed for the purpose of easing the child's immediate pain or suffering and which does not result in any physical harm to the child shall be punished as a Class 1 misdemeanor.

(d) Any other violation of this section shall be punished as a Class H felony.

SECTION 3. This act becomes effective December 1, 2003, and applies to offenses committed on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE FISCAL NOTE
(INCARCERATION NOTE G.S. 120-36.7)

BILL NUMBER: SB 226 1st Edition

SHORT TITLE: Unauthorized Admin. Meds. By Child Care Fac.

SPONSOR(S): Senator Purcell

FISCAL IMPACT

Yes (X) No ( ) No Estimate Available ( )

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
GENERAL FUND					
Correction					
Recurring		Unable to determine exact amount.			
Nonrecurring					
Judicial					
Recurring		Unable to determine exact amount.			
Nonrecurring					
TOTAL EXPENDITURES:		Unable to determine exact amount.			
ADDITIONAL PRISON BEDS*		Unable to determine exact number of beds.			
POSITIONS: (cumulative)					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Correction; Judicial Branch

EFFECTIVE DATE: December 1, 2003

**This fiscal analysis is independent of the impact of other criminal penalty bills being considered by the General Assembly, which could also increase the projected prison population and thus the availability of prison beds in future years. The Fiscal Research Division is tracking the cumulative effect of all criminal penalty bills on the prison system as well as the Judicial Department.*

BILL SUMMARY: SB 226 amends Chapter 110 of the General Statutes by adding a new section making it a Class H felony for an employee, owner, or operator of a licensed or unlicensed child care facility to administer any type of medication to a child attending the child care facility without first obtaining written or oral authorization from the child's parent or guardian or a "bona fide medical care provider". "Bona fide medical care providers" are limited to medical doctors, physician's assistants, registered nurses, or licensed practical nurses, emergency medical technicians, and paramedics.

ASSUMPTIONS AND METHODOLOGY:

Department of Correction

The Sentencing and Policy Advisory Commission prepares inmate population projections annually. The projections used for incarceration fiscal notes are based on January 2003 projections. These projections are based on historical information on incarceration and release rates under Structured Sentencing, crime rate forecasts by a technical advisory board, probation and revocation rates, and the decline (parole and maxouts) of the stock prison population sentenced under previous sentencing acts. Based on the most recent population projections and estimated available prison bed capacity, *there are no surplus prison beds available for the five year Fiscal Note horizon and beyond.* The number of beds needed will always be equal to the projected number of inmates due to a bill.

Because SB 226 creates a new offense, the Sentencing Commission does not have any historical data from which to estimate the impact of this bill on the prison population. It is not known how many offenders might be sentenced for this proposed offense. If there were three Class H felony convictions under the proposed statute per year, the combination of active sentences and probation revocations would result in the need for one additional prison bed the first year and two additional prison beds the second year. In 2001-2002, the statewide average operating cost for one inmate was $62.43/day or $22,786.95/year.

Judicial Branch

For most criminal penalty bills, the Administrative Office of the Courts (AOC) provides Fiscal Research with an analysis of the fiscal impact of the specific bill. For these bills, fiscal impact is typically based on the assumption that court time will increase due to an expected increase in trials and a corresponding increase in the hours of work for judges, clerks and prosecutors. This increased court time is also expected to result in greater expenditures for jury fees and indigent defense.

Because SB 226 provides for a new felony offense, AOC is unable to estimate the number of new felony charges. Because the Division of Child Development does not have data on how often medications are administered without prior authorization[2], AOC is unable to estimate the number of charges that could arise from the amended statute. For offenses that are brought to trial, the estimated court cost per trial is $4,986. For offenses not brought to trial, and where a guilty plea is entered, AOC estimates the cost per guilty plea at $248.

---

2 Administrative Office of the Courts Research and Planning Division.

SOURCES OF DATA: Department of Correction; Judicial Branch; North Carolina Sentencing and Policy Advisory Commission.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Nicole Kreiser

Jim Mills

APPROVED BY: James D. Johnson, Director, Fiscal Research Division

DATE: March 4, 2003

VISITOR REGISTRATION SHEET

Health and Human Resources — **March 5, 2003**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Eleuterio	AHHC
Jane Addison	DHHS - DCD
Liz Swift	NC Child Care Coalition
Peggy Ball	DHHS
Jane Buckley	DHHS
Rob Hamme	DHHS
W. Mark Benson	Capitol Group
Dave Reed	The Hope
Michelle Frazier	NC Bar Ass'n
Donna Hilt	DHHS
Jan McCoy	DHHS

VISITOR REGISTRATION SHEET

Health and Human Resources — **March 5, 2003**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Bethel	Div. of Aging
Jerry Cooper	NCACA
Abby Emanuelson	NMSS
John Cyrus	NC State Employees
Virginia Hebert	Intern – Sen. Kinnaird
Chris Nichols	Hunton + Williams
Giovanni Masucci	Capital City Consulting, Raleigh
BRUCE THOMPSON	PARKER POE
DAVID BARNES	Poyner + Spruill
ANAND RAMASWAMY	ASST. DA., ALAMANCE CO.
Steve Lynch	Investigator DA Alamance Co.

VISITOR REGISTRATION SHEET

Health and Human Resources — **March 5, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Richard Barbara Shevlin	Planned Parenthood
Jennifer Duke	Rep. Nye's Intern
[illegible]	District Atty - Chancery Ct.
[illegible]	nursing [illegible]
Marion Smith	GSK
[illegible]	NCMS
[illegible]	UHS
[illegible]	[illegible]
Jennifer Baron	WTVD-TV
Vicki Blount	WTVD-TV
Bill Scoggin	Kennedy Covington

VISITOR REGISTRATION SHEET

Health and Human Resources — **March 5, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Mitchell	Novartis
John Rose	NCFPC
C. Porter	Smith Anderson.
Beau Shark	AstraZeneca

AGENDA

SENATE HEALTH & HUMAN RESOURCES COMMITTEE
March 12, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

S.B. 244, Recognize Retired Nurses/Fees

S.B. 251, Prohibit Rebirthing Therapy

S.B. 262, MH Oversight Study Integration of Care

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, March 12, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 P.M. on Wednesday, March 12, 2003 in Room 544 of the Legislative Office Building. Ten members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Purcell recognized Senator Weinstein to explain his bill, SB 244, *Recognize Retired Nurses/Fees* to the Committee. He called on Polly Johnson, Executive Director of the Board of Nursing. She pointed out that through this bill, this will be the first time that retired nurses had had legal recognition instead of having to renew their licenses every two years. As long as they have not been out of practice for more than five years, there is no requirement for continuing education; longer than that they are required to take a refresher course. Senator Malone expressed concern over the fees listed in the bill. Ms. Johnson said that the current ceiling for reinstatement is the $180 listed in the bill, but currently the renewal fee is $72 per year, and the reinstatement fee is $105. However in case of national emergency it would be possible to require only the renewal fee. Senator Dannelly moved for a favorable report, seconded by Senator Lucas, passed, and has been referred to the Finance Committee.

Senator Purcell introduced Senator Foxx to present her bill, SB 262, *MH Oversight Study Integration of Care.* Senator Forrester asked if the Mental Health Oversight Committee has funds to fulfill the provisions of the bill; Senator Foxx responded that it does, that no funds will need to be appropriated. Senator Purcell called on Tara Larson, Deputy Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse, who gave an overview of the current state of mental health reform; that this reform is in the very beginning. Senator Malone said that hospital people have expressed concern that mental health and well as physical health issues would be imposed on them. Senator Fox pointed out that this is one of the concerns to be looked at in terms of children's mental health, that this is a multi-faceted issue, and how resources can be brought together. Senator Dannelly asked about a time limit. Senator Foxx pointed out that there is a requirement for a progress report and a final report due in 2005. Ms. Larson told the committee that a task force has been assigned specifically to work on issues with the Hospital Association. Senator Malone asked to be invited to meetings of this task force. Senator Dannelly moved for a favorable report, seconded by Senator Lucas. The bill passed with no referral.

The meeting adjourned at 12:25 P.M.

William R. Purcell
Senator William R. Purcell, CoChair

Stan Bingham
Senator Stan Bingham, CoChair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH AND HUMAN RESOURCES COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, March 12, 2003

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

FAVORABLE

S.B. **244** Recognize Retired Nurses/Fees.
Sequential Referral: Finance
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH AND HUMAN RESOURCES COMMITTEE REPORT

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, March 13, 2003

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

FAVORABLE

S.B. **262** MH Oversight Study Integration of Care.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 244

Short Title:	Recognize Retired Nurses/Fees.	(Public)
Sponsors:	Senators Weinstein; Purcell and Soles.	
Referred to:	Health and Human Resources.	

February 27, 2003

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF NURSING TO RECOGNIZE RETIRED NURSES BY SPECIAL LICENSURE STATUS AND TO ESTABLISH A FEE FOR THIS STATUS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-171.36A. Retired nurse status; reinstatement.**

(a) After a registered nurse or a licensed practical nurse has retired, upon payment of the one-time fee required by G.S. 90-171.27(b), the Board may issue a special license to a registered nurse or licensed practical nurse in recognition of the nurse's retired status.

(b) If a retired registered nurse or licensed practical nurse wishes to return to the practice of nursing, the retired nurse shall apply for reinstatement on a form provided by the Board and satisfy any requirements the Board deems necessary to reinstate the license."

SECTION 2. G.S. 90-171.27(b) reads as rewritten:

"(b) The schedule of fees shall not exceed the following rates:

Application for examination leading to certificate and license as registered nurse $75.00

Application for certificate and license as registered nurse by endorsement 150.00

Application for each re-examination leading to certificate and license as registered nurse 75.00

Renewal of license to practice as registered nurse (two-year period) 100.00

Reinstatement of lapsed license to practice as a registered nurse and renewal fee 180.00

Application for examination leading to certificate and license as

licensed practical nurse by examination 75.00
Application for certificate and license as licensed practical nurse by endorsement 150.00
Application for each re-examination leading to certificate and license as licensed practical nurse 75.00
Renewal of license to practice as a licensed practical nurse (two-year period) 100.00
Reinstatement of lapsed license to practice as a licensed practical nurse and renewal fee 180.00
Application fee for retired registered nurse status or retired .....licensed practical nurse status..... 50.00
Reasonable charge for duplication services and materials.

A fee for an item listed in this schedule shall not increase from one year to the next by more than twenty percent (20%)."

SECTION 3. This act is effective when it becomes law.

SENATE BILL 244:
Recognize Retired Nurses/Fees

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Sen. Weinstein
Date:	March 12, 2003	**Summary by:**	Amy Compeau Research Division Staff
Version:	First Edition		

SUMMARY: ***Senate Bill 244 would establish a one-time fee for the issuance of a special license to recognize a retired registered nurse or a licensed practical nurse. The bill would also establish procedures to reinstate a lapsed license of a retired registered nurse or licensed practical nurse who wishes to resume the practice of nursing. The bill would become effective when it becomes law.***

CURRENT LAW: No category currently exists for the recognition of a retired licensed practical nurse (LPN) or a retired registered nurse (RN). Upon retirement a LPN or a RN can: (1) become inactive and be considered unlicensed, (2) pay a renewal fee every two years of up to $100 to maintain an active license or (3) pay a fee of up to $180 to reinstate a lapsed license and resume practice.

BILL ANALYSIS:

Retired Nurse Status

SB 244 allows retired LPNs and retired RNs a way to be recognized for their service. SB 244 would establish a one-time application fee up to $50 that would be payable to the North Carolina Board of Nursing (Board) for the issuance of a special license to a LPN or a RN in recognition of the nurse's retired status.

A retired nurse status would allow LPNs and RNs at the end of their nursing careers to obtain legal title recognition. According to the North Carolina Board of Nursing, a retired nurse status would help the North Carolina Center for Nursing (Center) obtain a more accurate "count" of nurses who are licensed but not in the workforce. The Center would be able to identify retired nurses who are not potential "returnees" to the workforce, which would help the Center better calculate current and future nursing workforce supply and demand.

Reinstatement of Retired Nurses to Active Status

The bill would require a LPN or a RN to apply for reinstatement on a form provided by the North Carolina Board of Nursing and to satisfy any requirements the Board deems necessary to reinstate the license.

S244-SMAC-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 262*

Short Title:	MH Oversight Study Integration of Care.	(Public)
Sponsors:	Senators Foxx, Metcalf, Allran, Dannelly, Lucas, Purcell; Apodaca, Ballantine, Brock, Carpenter, Clodfelter, Dorsett, Horton, Kinnaird, Queen, and Soles.	
Referred to:	Health and Human Resources.	

March 3, 2003

A BILL TO BE ENTITLED

AN ACT DIRECTING THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO STUDY INTEGRATION OF CARE FOR CHILDREN WITH MULTIPLE SYSTEM SERVICE NEEDS.

Whereas, current governmental services to children with multiple service needs are characterized by duplicated and often conflicting assessments, barriers to timely and appropriate access to services, and lack of satisfactory outcomes; and

Whereas, individual service agencies have missions that differ from one another and these differences inhibit meaningful interagency collaboration and appropriate access to services; and

Whereas, agencies serve children that meet the individual agency's eligibility criteria, the problem of appropriate access is most acute with children who have multiple problems but are denied services by one or more agencies; and

Whereas, new models have emerged for implementing effective service delivery, including blended funding, interagency case management, lead agency delivery, and joint purchasing; and

Whereas, North Carolina has not revamped its approaches to children with multisystem involvement beyond interagency planning, although some local entities have developed innovative approaches; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services ("Oversight Committee") shall study issues pertaining to the integration of care for children with multiple system service needs. In conducting the study, the Oversight Committee shall do the following:

(1) Study state-of-the-art approaches to services to children with multiple system service needs as the basis of reform in North Carolina.
(2) Survey and analyze evidence-based best practices in North Carolina and elsewhere for potential systemwide adoption.
(3) Identify barriers to access for developing a uniform access process to implement a "no wrong door" policy such that children and families may enter any service access point but will be afforded seamless access to all necessary services.
(4) Recommend changes to North Carolina service systems involving mental health, developmental disabilities, and substance abuse services, social services, education services, juvenile justice, and other related service systems that will promote meaningful and effective interagency collaboration and satisfactory outcomes for children and families.
(5) Provide estimates on the fiscal impact of proposed changes to the service systems.

SECTION 1.(b) The Oversight Committee may hire a consultant and may establish an advisory committee to work with the consultant in conducting the study. The Cochairs of the Oversight Committee may appoint the members of the advisory committee. Membership on the advisory committee shall include representatives of the service systems involved and consumers or other members of the public at large. The Oversight Committee shall determine the extent and scope of the study in accordance with subsection (a) of this section and shall establish interim and final reporting time lines for the consultant's findings and recommendations.

SECTION 1.(c) With the prior approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist in the work of the Oversight Committee and its advisory committee. With the prior approval of the Legislative Services Commission, the Oversight Committee and its advisory committee may hold its meetings in the State Legislative Building or the Legislative Office Building.

SECTION 1.(d) The Oversight Committee may submit a progress report on the results of the study, including recommended legislation, to the 2003 General Assembly, Regular Session 2004, upon its reconvening, and shall report on the study, including recommended legislation, to the 2005 General Assembly, upon its convening. All reports shall be filed with the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Legislative Librarian. The Oversight Committee shall provide copies of its reports to system entities such as social services, juvenile justice, education, and other appropriate entities.

SECTION 1.(e) Members of the Oversight Committee and its advisory committee shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 1.(f) All State departments and agencies shall cooperate with the Oversight Committee and its advisory committee and, upon request, shall furnish to the

Oversight Committee and its staff any information in their possession or available to them.

SECTION 2. From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Oversight Committee, including expenses of advisory committee members and consultant costs.

SECTION 3. This act is effective when it becomes law.

SENATE BILL 262:
MH Oversight Study Integration of Care

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Sen. Foxx
		Summary by:	Linda Attarian Committee Counsel
Date:	March 12, 2003		
Version:	Introduced		

SUMMARY: ***Senate Bill 252 directs the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (Oversight Committee) to study issues pertaining to the integration of care for children with multiple needs that transcend service systems. The Oversight Committee is to make a final report to the 2005 General Assembly. The bill is effective when it becomes law.***

CURRENT LAW: The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services was established by the 1999 General Assembly to examine 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 membership consists of 16 members of the General Assembly, each serving two-year terms, which begin on the convening of the General Assembly in each odd-numbered year.

BILL ANALYSIS: The bill directs the Oversight Committee to study issues pertaining to the integration of care for children with multiple services system needs and to make recommendations for changes to the State's service system for children that will "promote meaningful and effective interagency collaboration and satisfactory outcomes for children and families." In conducting the study, the Oversight Committee must complete certain tasks and objectives. See Section 1(a).

The Oversight Committee is authorized to hire a consultant and to establish an advisory committee to work with the consultant in conducting the study. See Section 1(c).

The Oversight Committee may submit an interim report to the 2003 General Assembly upon the convening of the 2004 Regular Session and must make a final report, including proposed legislation, to the 2005 General Assembly, upon its convening. See Section 1(d).

The Legislative Services Commission shall allocate funds for expenses related to the study, including for the advisory committee and consultant costs, from funds allocated to it from the General Assembly.

BACKGROUND:

The members of the Oversight Committee discussed this legislative proposal on February 24, 2003. Alice Lin, the Committee's Project Director reported that the rationale for the bill includes the following:

- Current governmental services to children with multiple service needs are characterized by duplicated and often conflicting assessments, barriers to timely and appropriate access to services, and lack of satisfactory outcomes;
- Individual service agencies have missions that differ from one another and these difference inhibit meaningful interagency collaboration and appropriate access to services;

- Agencies serve children that meet the individual agency's eligibility criteria, the problem of appropriate access is most acute with children who have multiple problems but are denied services by one or more agencies'
- New models have emerged for implementing effective service delivery, including blended funding, interagency case management, lead agency delivery, and joint purchasing;
- North Carolina has not revamped its approaches to children with multi-system involvement beyond interagency planning, although some local entities have developed innovative approaches.

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **March 12, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stella McKenney	NC DHHS
DAVID BARNES	Poyner + Spruill LLP
Hugh Tilson	NCHA
Evelyn Hayes Thorne	CHCR
J Craig Lunsford	UHS
John Cyrus	N.C. State Troopers
Camille Stell	Kennedy Covington
Jeffrey Franklin Griffin	UNCG Doctoral Intern VCCS
Martha Lawrence	
Tasha Clay	YAIO
Kathy Johnson	Nurse of the Day

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **March 12, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOSEPH WHITLARK	DOCTOR OF THE DAY
Deborah Wilson	Robeson County Mental Health Center
Nancy Lovette	Robeson County Mental Health Center
Virginia Hebert	Intern - Sen Kinnaird
Joanne Stevens	nursing
Polly Johnson	NC Board of Nursing
Kathleen Oathout	NAMI - Wilmington, NC
Cara Oathout	NAMI - Wilmington, NC
SAM OATHOUT	NAMI - WILMINGTON
TOMMY SUTTON	WYETH

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, March 19, 2003 at 11:00 AM
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

- **SB 252** — **CAP/DA Audit/DHHS Report**
- **SB 204** — **Local Long-Term Care Planning Pilot Project**
- **SB 251** — **Prohibit Rebirthing Therapy**

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, March 19, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, March 19, 2003 in Room 544 of the Legislative Office Building. Twelve members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator William R. Purcell, Co-Chair, welcomed the committee members present. There were no pages.

Senator Bingham recognized Senator Purcell to explain his bill, SB 252, *CAP/DA Audit/DHHS Report.* There has been a lot of discussion about the CAPS program which is Community Alternatives Program for Disabled Adults that allows them to stay at home rather than be treated in a nursing home. There has been a lot of discussion whether it is really cheaper to be cared for at home or in a nursing facility. The bill ask that the state auditor conduct an audit. Since 1995 in home services have increased from 18.5% to 35.8% of the Medicaid expenditures. The bill will appropriate money for the audit. Senator Forrester moved for a favorable report and re-referral to appropriation, seconded by Senator Lucas.

Senator Bingham recognized Senator Purcell to explain, SB 204, ***Local LTC Planning Pilot Project***. SB 204 is another one of a number of bills that has come from the Study Commission on Aging and Senator Purcell asked Committee Staff Diane Jessup to explain the bill. Diane Jessup said currently there are a variety of groups that are responsible for different aspects of long term care at the local level but different counties handle it in different ways. Some of it has to do with funding streams. Section I of the bill would require the department to implement a communication and planning initiatives to support local planning. Last session the commission recommended that DHHS conduct a study based on The Institute of Medicine (IOM) Long Term Care Task Force finding that these long term care services are fragmented at the local level. Then the General Assembly directed DHHS in last session to study whether counties should designate a local lead agency to coordinate a local long-term care planning process at the county or regional levels. In response DHHS conducted a study and presented a report to the study commission recommending that the General Assembly fund a pilot project on long term care with local lead agencies to pilot this concept to see how it goes. Senator Forrester made the motion for a favorable report and re-referred to Appropriations. Senator Lucas asked how many pilots. Karen Catovia, Director of the Division of Aging, said there will be two initiatives and the funding will be expected to be equal between the two counties. They would like to have geographic differences as well as urban and rural. The motion carried unanimously for a favorable report and re-referred to Appropriations.

Senator Bingham recognized Senator Allran to present his bill, SB 251, ***Prohibit Rebirthing Therapy***. This bill was brought up because a ten year old North Carolina girl named Candace Newmaker was subjected to a type of quackery called rebirthing in 1999. Candace and some other children around the country have died from the procedure. This girl's grandparents and residents of North Carolina, are here in the audience today. They have pursued this as a mission, to get it outlawed. There is a Proposed Committee Substitute to the original bill and Senator Forrester made the motion to hear the Proposed Committee Substitute for discussion. The motion carried. Senator Lucas asked what was changed in the Proposed Committee Substitute. Senator Allran said that everywhere in the original bill where Rebirthing Therapy was used it was replaced with Rebirthing Technique. That was done at the request of the Psychiatry Association because they support the committee substitute. They had a problem with the way it was originally written because they did not want to give any type of creditability to this by calling it therapy. Senator Lucas wants to go on record as supporting this bill and at the appropriate time to

make the motion. Senator Purcell said that assault is already against the law in NC so why do we need another assault law.. Senator Allran said what they want to do is to send a message that this technique is prohibited. Senator Purcell asked if the bill is written so it will keep these type of people that do this weird stuff from calling it something else. Senator Allran hopes so. Senator Queen asked Senator Allran to explain what you are prohibiting. Senator Allran explained when a child, usually adopted, does not bond they consider it an attachment disorder. According to the theory of these people if you do not bond with this child that you have brought into your home the only way to make that child bond is to redo or reenact the birthing process. They took blankets and pillows and covered the poor child up and over a period of about an hour and a half and tortured her until she suffocated and died. This is suppose to make them be so broken down that they will not revolt anymore and is like you beat a dog enough the dog will come back to you and coward. They compare it a lot to the way you have to break a horse or an animal, you have to break the child's spirit. Senator Hartsell ask if the people were charged with a crime. Staff Dianna Jessup stated there were two unlicensed therapist and they were both convicted of child abuse resulting in death and received sixteen years in prison and the mother plead guilty to negligence child abuse resulting in death and received a four year deferred sentence and 400 hours of community service. Senator Lucas moved for a favorable report to the Proposed Committee Substitute and unfavorable to the original bill and re-referred to Judiciary II. The motion carried unanimously.

Senator Bingham thanked the Grandparents for what they have done and recognized former Governor Martin who was at the meeting.

The meeting adjourned at 11:35 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH AND HUMAN RESOURCES COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, March 19, 2003

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

FAVORABLE

S.B. **204** Local LTC Planning Pilot Project.
Sequential Referral: None
Recommended Referral: Appropriations/Base Budget

S.B. **252** CAP/DA Audit/DHHS Report.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **251** Prohibit Rebirthing Therapy.
Draft Number: PCS 55092
Sequential Referral: None
Recommended Referral: Judiciary II
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 252*

Short Title:	CAP/DA Audit/DHHS Report.	(Public)
Sponsors:	Senators Purcell and Swindell.	
Referred to:	Health and Human Resources.	

February 27, 2003

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE AUDITOR TO PERFORM AN AUDIT OF THE COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA) AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTINUE ITS EXAMINATION OF CAP/DA AND REPORT TO THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The State Auditor shall perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA). The audit shall build upon the results of the study conducted in accordance with S.L. 2002-126, Section 10.16(c), by the North Carolina Institute of Medicine and shall provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor shall report the results of the audit to the North Carolina Study Commission on Aging by January 1, 2004.

SECTION 1.(b) There is appropriated to the Office of State Auditor the sum of one hundred fifty thousand dollars ($150,000) for the 2003-2004 fiscal year to fund the CAP/DA audit prescribed in this section.

SECTION 2. The Department of Health and Human Services shall continue to examine CAP/DA and shall make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004. The report shall include the following information:

(1) A review of the current assessment process for CAP/DA clients, including an explanation of how assessments are conducted and a comparison of the assessment process for CAP/DA clients with the assessment process for nursing home and adult care home clients.

(2) A description of total program costs to the State and counties for clients receiving CAP/DA payments and an analysis of per client costs in CAP/DA to per client costs in nursing homes and adult care homes.

This analysis shall include the costs of all forms of assistance received by CAP/DA clients, such as food stamps and housing assistance.

(3) A description of the monitoring of quality of care for CAP/DA clients.

(4) An evaluation of the current waiting list procedures.

SECTION 3. This act becomes effective July 1, 2003.

SENATE BILL 252:
CAP/DA Audit/DHHS Report

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Senators Purcell and Swindell
Date:	March 19, 2003	**Summary by:**	Dianna Jessup Committee Counsel
Version:	First Edition		

SUMMARY: Senate Bill 252 is a recommendation of the North Carolina Study Commission on Aging. The bill would direct the Office of the State Auditor to perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA) and report the results of the audit to the North Carolina Study Commission on Aging (Commission) by January 1, 2004. The bill would appropriate funds to the Office of the State Auditor for the CAP/DA audit. In addition, SB 252 would direct the Department of Health and Human Services (DHHS) to continue to examine CAP/DA and make a report of its findings to the Commission by January 1, 2004. The bill would become effective July 1, 2003.

CURRENT LAW: The Community Alternatives Program for Disabled Adults (CAP/DA) started in July 1982 and operates under a Medicaid Home and Community-Based Services waiver. For individuals who qualify for Medicaid, and who would otherwise require care in a nursing facility, CAP/DA provides the opportunity to be cared for at home. CAP/DA pays for services including adult day health care, in-home aide services, home delivered meals, home mobility aids, respite care, and telephone alert. CAP/DA is a statewide program administered by the lead agency in each county. In September 2001, due to budget constraints, entry into CAP/DA was "frozen". The "freeze" continued until August 2002. In 2002, the General Assembly directed the Institute of Medicine (IOM) to study CAP/DA and recommend ways of improving the administration of the program.

BILL ANALYSIS: **Section 1** of the bill would appropriate $150,000 for FY 2003-2004 to the Office of the State Auditor to perform a CAP/DA audit that would build upon the results of the North Carolina Institute of Medicine (NC IOM) study, that was required by S.L. 2002-126, Sec. 10.16(c). The State Auditor must report the results of the audit to the Commission by January 1, 2004.

Section 2 of the bill would direct DHHS to continue to examine CAP/DA and make a report of its findings to the Commission by January 1, 2004. The report must include the following:

1. A review of the current assessment process for CAP/DA clients, including an explanation of how assessments are conducted and a comparison of the assessment process for CAP/DA clients with the assessment process for nursing home and adult care home clients.
2. A description of total program costs to the State and counties for clients receiving CAP/DA payments and an analysis of per client costs in CAP/DA to per client costs in nursing homes and adult care homes.
3. A description of the monitoring of quality of care for CAP/DA clients. This analysis must include the costs of all forms of assistance received by CAP/DA clients, such as food stamps and housing assistance.
4. An evaluation of the current waiting list procedures.

Section 3 of the bill would make the bill become effective July 1, 2003.

BACKGROUND: Senate Bill 252 is a recommendation of the Aging Study Commission to the 2003 General Assembly. S.L. 2002-126 (SB 1115) Section 10.16(c) required the NC IOM to conduct a study of the CAP/DA program administered by DHHS and to recommend ways of improving the administration of CAP/DA. The NC IOM was directed to report its findings and recommendations to the 2003 General Assembly upon its convening. The NC IOM reported preliminary findings and recommendations to the Commission. However, the Commission felt the NC IOM report did not fully contemplate the issues that an audit would explore. The Commission also heard a presentation from the Division of Medical Assistance, DHHS, regarding the relative costs for CAP/DA, adult care homes, and nursing facilities. Clear data comparisons were not readily available, so a definitive answer to the question of cost effectiveness of the CAP/DA program remains unanswered. Therefore, the Commission recommended that the State Auditor conduct an audit of the CAP/DA program and that DHHS continue its examination of the CAP/DA program.

Amy Compeau, Research Assistant, contributed to this summary.

S252-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 204*

Short Title:	Local LTC Planning Pilot Project.	(Public)
Sponsors:	Senators Swindell and Purcell.	
Referred to:	Health and Human Resources.	

February 26, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING.

The General Assembly of North Carolina enacts:

SECTION 1. In response to Recommendation #16 in the final report from the Institute of Medicine Task Force on Long-Term Care and the study report recommendations resulting from S.L. 2001-491, Part XXII, the Department of Health and Human Services shall implement a communications and planning initiative to support local planning for long-term care and shall pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. For those counties that voluntarily participate, the local long-term care planning initiative shall aid in the development of core services, coordinate local planning, and streamline access to services. The initiative shall eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services.

SECTION 2. The Department shall submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.

SECTION 3. There is appropriated to the Department of Health and Human Services the sum of seventy thousand dollars ($70,000) for the 2003-2004 fiscal year and ninety thousand dollars ($90,000) for the 2004-2005 fiscal year to fund the pilot project established in this act.

SECTION 4. This act becomes effective July 1, 2003.

SENATE BILL 204:
Local LTC Planning Pilot Project

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Senators Swindell and Purcell
		Summary by:	Dianna Jessup Committee Counsel
Date:	March 19, 2003		
Version:	First Edition		

SUMMARY: Senate Bill 204 would appropriate funds to the Department of Health and Human Resources to implement a pilot project for local long-term care planning. The bill would become effective July 1, 2003.

CURRENT LAW: Currently, there are a variety of groups and agencies responsible for different aspects of long term care services for older and disabled adults at the county level, including CAP-DA boards, social service boards, area mental health, developmental disabilities, and substance abuse boards, and aging planning bodies. In addition, may counties have Healthy Carolinians Task Forces and Mayors' and Local Committees for People with Disabilities. Each of these local long-term care planning bodies operate under different funding sources. While some local planning bodies work well together to accomplish similar goals, planning at the local level is generally not coordinated.

BILL ANALYSIS: **Section 1** of the bill would require the Department of Health and Human Services (DHHS) to implement a communications and planning initiative to support local planning for long-term care and to pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. The local long-term care planning initiative (Initiative) would aid participating counties with: (1) the development of core services, (2) the coordination of local planning and (3) streamlining access to services. The Initiative would do the following:

1. Eliminate fragmentation and barriers to information and services;
2. Provide a seamless connection among State agencies and local entities, regardless of funding sources; and
3. Allow consumers to efficiently and effectively navigate among long-term care services.

Section 2 of the bill would require DHHS to submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.
Section 3 of the bill would appropriate $70,000 for FY 2003-2004 and $90,000 for FY 2004-2005 to DHHS to fund the pilot project.
Section 4 of the bill would make the bill become effective July 1, 2003.

BACKGROUND: This bill is a recommendation from the North Carolina Study Commission on Aging (Commission) to the 2003 General Assembly. The Commission recommended to the 2001 General Assembly that DHHS conduct a study based on the Institute of Medicine's (IOM) Long-Term Care Task Force finding that "long-term care services are often fragmented, duplicative, complex, and not consumer-friendly and that many counties lack needed core long-term care services." In response to the Commission's recommendation, the General Assembly directed DHHS in the 2001 Studies Bill (S.L. 2001-491, Part XXII) to study whether counties should designate local lead agencies to organize a local long-term care planning process, as described in Recommendation #16 of the IOM Long-Term Care Task

Force final report in January 2001. The IOM had recommended that the General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level and suggested how local planning processes should be organized. The Commission heard presentations from DHHS regarding their report in response to S.L. 2001-491, Part XXII and recommended that the General Assembly fund a pilot project on long-term care local lead agencies.

Amy Compeau, Research Assistant, contributed to this summary.

S204-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 251

Short Title:	Prohibit Rebirthing Therapy.	(Public)
Sponsors:	Senators Allran; Apodaca, Ballantine, Bingham, Carpenter, Clodfelter, Dalton, Forrester, Foxx, Garrou, Garwood, Hartsell, Horton, Hoyle, Jenkins, Lucas, Purcell, Rand, Shubert, Sloan, and Tillman.	
Referred to:	Health and Human Resources.	

February 27, 2003

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE PRACTICE OF THE REBIRTHING THERAPEUTIC TECHNIQUE.

Whereas, United States Representative Sue Myrick, a member of the North Carolina Congressional delegation, introduced House Concurrent Resolution 435 in Congress encouraging states to outlaw rebirthing therapy; and

Whereas, the United States Congress adopted House Concurrent Resolution 435, which passed the House of Representatives by a vote of 397-0; and

Whereas, in House Concurrent Resolution 435 the United States Congress expressed the sense that the therapeutic technique known as rebirthing, a form of attachment therapy, is a dangerous and harmful practice and should be prohibited; and

Whereas, Candace Newmaker, a child from North Carolina, died from use of the rebirthing technique, and four other children have died from other forms of attachment therapy; and

Whereas, the American Psychological Association does not recognize rebirthing as proper treatment, Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 52 of Chapter 14 of the General Statutes is amended by adding the following new section to read:

"**§ 14-401.21. Practicing rebirthing therapeutic technique; penalty.**

(a) It is unlawful for a person to practice the therapeutic technique of rebirthing. As used in this section, "rebirthing" means a therapy to reenact the birthing process in a manner that includes restraint and creates a situation in which a patient may suffer physical injury or death.

(b) A violation of this section is punishable as follows:

(1) For a first offense under this section, the person is guilty of a Class A1 misdemeanor.

(2) For a second or subsequent offense under this section, the person is guilty of a Class I felony."

SECTION 2. G.S. 122C-60(a) reads as rewritten:

"(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. For purposes of this section, rebirthing as defined by G.S. 14-401.21 is not 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."

SECTION 3. Section 1 of this act becomes effective December 1, 2003, and applies to offenses committed on and after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 251
PROPOSED COMMITTEE SUBSTITUTE S251-PCS55092-SW-3

Short Title: Prohibit Rebirthing. (Public)

Sponsors:

Referred to:

February 27, 2003

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE PRACTICE OF THE "REBIRTHING" TECHNIQUE.

Whereas, United States Representative Sue Myrick, a member of the North Carolina congressional delegation, introduced House Concurrent Resolution 435 in Congress encouraging states to outlaw "rebirthing"; and

Whereas, the United States Congress adopted House Concurrent Resolution 435, which passed the House of Representatives by a vote of 397-0; and

Whereas, in House Concurrent Resolution 435, the United States Congress expressed the sense that the technique known as "rebirthing", a form of "attachment therapy", is a dangerous and harmful practice and should be prohibited; and

Whereas, Candace Newmaker, a child from North Carolina, died from use of the "rebirthing technique", and four other children have died from other forms of "attachment therapy"; and

Whereas, the American Psychological Association does not recognize "rebirthing" as proper treatment; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 52 of Chapter 14 of the General Statutes is amended by adding the following new section to read:

"**§ 14-401.21. Practicing "rebirthing technique"; penalty.**

(a) It is unlawful for a person to practice the technique of "rebirthing". As used in this section, "rebirthing" means a technique to reenact the birthing process in a manner that includes restraint and creates a situation in which a patient may suffer physical injury or death.

(b) A violation of this section is punishable as follows:

(1) For a first offense under this section, the person is guilty of a Class A1 misdemeanor.

(2) For a second or subsequent offense under this section, the person is guilty of a Class I felony."

SECTION 2. G.S. 122C-60(a) reads as rewritten:

"(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. For purposes of this section, "rebirthing" as defined by G.S. 14-401.21 is not 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."

SECTION 3. Section 1 of this act becomes effective December 1, 2003, and applies to offenses committed on and after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 251
PROPOSED COMMITTEE SUBSTITUTE S251-CSSW-3 [v.1]

3/18/2003 3:22:19 PM

Short Title: Prohibit Rebirthing. (Public)

Sponsors:

Referred to:

February 27, 2003

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE PRACTICE OF THE "REBIRTHING" TECHNIQUE.

Whereas, United States Representative Sue Myrick, a member of the North Carolina Congressional delegation, introduced House Concurrent Resolution 435 in Congress encouraging states to outlaw "rebirthing"; and

Whereas, the United States Congress adopted House Concurrent Resolution 435, which passed the House of Representatives by a vote of 397-0; and

Whereas, in House Concurrent Resolution 435 the United States Congress expressed the sense that the technique known as "rebirthing", a form of "attachment therapy", is a dangerous and harmful practice and should be prohibited; and

Whereas, Candace Newmaker, a child from North Carolina, died from use of the "rebirthing technique", and four other children have died from other forms of "attachment therapy"; and

Whereas, the American Psychological Association does not recognize "rebirthing" as proper treatment, Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 52 of Chapter 14 of the General Statutes is amended by adding the following new section to read:

"**§ 14-401.21. Practicing "rebirthing technique"; penalty.**

(a) It is unlawful for a person to practice the technique of "rebirthing". As used in this section, "rebirthing" means a technique to reenact the birthing process in a manner that includes restraint and creates a situation in which a patient may suffer physical injury or death.

(b) A violation of this section is punishable as follows:

(1) For a first offense under this section, the person is guilty of a Class A1 misdemeanor.

(2) For a second or subsequent offense under this section, the person is guilty of a Class I felony."

SECTION 2. G.S. 122C-60(a) reads as rewritten:

"(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. For purposes of this section, "rebirthing" as defined by G.S. 14-401.21 is not 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."

SECTION 3. Section 1 of this act becomes effective December 1, 2003, and applies to offenses committed on and after that date. The remainder of this act is effective when it becomes law.

SENATE BILL 251:
Prohibit Rebirthing Therapy

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Senator Allran
		Summary by:	Dianna Jessup Committee Counsel
Date:	March 19, 2003		
Version:	**PCS S251-CSSW-3**		

SUMMARY: ***Senate Bill 251 would make it a criminal offense to practice the technique of "rebirthing", meaning a technique to reenact the birthing process in a manner that includes restraint and creates a situation in which a patient may suffer physical injury or death. A criminal charge would be punishable as a Class A1 misdemeanor for the first offense (resulting up to 150 days' community/intermediate/active punishment) and a Class I felony for subsequent offenses (resulting in a minimum of 3 months' community punishment and a maximum of 12 months' intermediate/active punishment). This section of the bill would become effective December 1, 2003.***

The bill would also specify that the rebirthing technique is not a permissible form of physical restraint under the mental health statutes. This section of the bill would become effective when it becomes law.

The PCS would remove the phrases "therapy" or "therapeutic" from the bill. Anyone practicing the rebirthing technique, whether or not intended as therapy, would be subject to the criminal penalties in the bill.

CURRENT LAW:

Criminal law currently does not specifically prohibit "rebirthing", but depending on the circumstances and whether injury or death occurs, conducting "rebirthing" could result in criminal charges.

Child abuse: Any parent of a child less than 16, or any other person providing care to or supervision of a child, who inflicts physical injury, or who allows physical injury to be inflicted, or who creates or allows to be created a substantial risk of physical injury, upon or to the child by other than accidental means is guilty of **misdemeanor child abuse**. Misdemeanor child abuse is a Class 1 misdemeanor offense, punishable by up to 45 days' community punishment. Intentional infliction of serious physical injury, or an intentional assault on a child which results in serious physical injury[1], is **felony child abuse**, a Class E felony punishable by 15-74 months' intermediate/active punishment. If serious bodily injury[2] to the child occurs, it is a Class C felony punishable by 44 to 210 months' active punishment.

Assault: A **simple assault**, i.e., an overt act or attempt, or the unequivocal appearance of attempt, with force and violence, to immediately physically injury another person, with the show of force or menace of violence being sufficient to put a reasonable person in fear of immediate physical injury, is a Class 2 misdemeanor, punishable by up to 60 days' community/intermediate/active punishment. If the assault is on a child under 12, or if serious injury is inflicted, it is a Class A1 misdemeanor, punishable by up to 150 days' community/intermediate/active punishment.

[1] "Serious physical injury" may be physical injury that causes great pain and suffering or serious mental injury.

[2] "Serious bodily injury" is bodily injury that creates a substantial risk of death, or that causes serious permanent disfigurement, coma, a permanent or protracted condition that causes extreme pain, or permanent or protracted loss or impairment of the function of any bodily member or organ, or that results in prolonged hospitalization.

Manslaughter/Murder: A person is guilty of **involuntary manslaughter** even though an act that caused death is lawful, if the act was carried out in a reckless and careless manner with respect to the rights and safety of others. Involuntary manslaughter is a Class F felony, punishable by 10 months' intermediate/active to 49 months' active punishment. If a death results from cruel and reckless acts that indicate a total disregard for human life, a person could be charged with **second degree murder**, which is a Class B2 felony, punishable by 94-392 months' active punishment.

Other: Under the mental health statutes[3], if an employee of or a volunteer at a facility, who other than as part of generally accepted medical or therapeutic procedure, knowingly causes pain or injury to a client, that person is guilty of a Class 1 misdemeanor (punishable by up to 120 days' community/intermediate/active punishment.

The **use of physical restraint** on a client under the mental health statutes is limited to circumstances when there is imminent danger of abuse or injury to the client or others, when substantial property damage is occurring, or when the restraint is necessary as a measure of therapeutic treatment. All instances of restraint must be documented and must be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to restraint.

BILL ANALYSIS: If enacted, it would be a specific criminal offense to practice rebirthing, whether or not a patient is actually injured during the therapy. A criminal charge would be punishable as a Class A1 misdemeanor for the first offense (resulting up to 150 days' community/intermediate/active punishment) and a Class I felony for subsequent offenses (resulting in a minimum of 3 months' community punishment and a maximum of 12 months' intermediate/active punishment). The bill would not change current law as it relates to child abuse, assault, manslaughter, and murder, so if circumstances warranted, a person practicing rebirthing could still be charged with one of these offenses.

The bill would also specify that rebirthing is not an acceptable form of mental health therapeutic treatment that would permit the use of restraint on a client.

BACKGROUND: Candace Newmaker, a 10-year old girl from Durham, North Carolina, died on April 19, 1999, a day after a rebirthing session in the home of an unlicensed therapist in Colorado. During the session, the child was wrapped in a sheet, made to lie in the fetal position, and then huge pillows were placed over her. Four adults pushed against her while her mother urged the child to be "born" to her, to come out of the "womb" and start a new and better life. During the procedure, the child screamed and begged for air, telling them she would die, to which the therapists replied, "Go ahead and die". When the child was unwrapped 70 minutes later, she wasn't breathing, and she died the next day. The therapy was supposed to help cure the child's attachment disorder, characterized by violent behavior towards her mother.

The two unlicensed therapists were convicted of child abuse resulting in death and received 16 years in prison as punishment. The child's mother pled guilty to negligent child abuse resulting in death and was given a four-year deferred sentence and 400 hours of community service.

In 2001, Colorado enacted legislation, known as "Candace's Law" that outlaws rebirthing therapy.

S251-SMSW-001

[3] G.S. 122C-66(a).

VISITOR REGISTRATION SHEET

Health and Human Resources — March 19, 2003

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Camille Stell	Kennedy Covington
Barbara Brooks	Division of Medical Assistance
Julie Bell	NC Division of Aging
Karen Gottovi	Div of Aging
Jan Mabry	GOV OFFICE
Joanne Stevens	nursing
Stan Munsie	MLB
[illegible]	NCAHP
Cynthia Finch	AHCD
Mary E. Davis	Prohibit Rebirthing
David A. Davis	Prohibit Rebirthing

VISITOR REGISTRATION SHEET

Health and Human Resources — March 19, 2003

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheila McCoy	NC DHHS
Jim Martin	Carolinas HealthCare System
Virginia Hebert	Sen Kinnaird's Office

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 2, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- SB 507, *Medicaid Cost Saving Measures*
- SB 522, *Board of Nursing*
- HB 36, *Repeal Involuntary Sterilization*
- SB 519, *Child Lead Poisoning Prevention Prg Amends.-AB*

III. Other Business

IV. Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 2, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 P.M. on Wednesday, April 2, 2003 in Room 544 of the Legislative Office Building. Thirteen members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Purcell asked Senator Rand to explain his bill, SB 507, *Medicaid Cost Saving Measures*, to the committee. Senator Reeves asked if the new cards could be used with existing card readers; Senator Rand replied that they could. Senator Dannelly moved that this bill be given a favorable report. It passed, with a sequential referral to the Appropriations Committee.

Senator Rand went on to present his bill, SB 522, *Board of Nursing*, to the committee. This bill has a proposed committee substitute and an amendment to the proposed committee substitute. Senator Purcell explained the amendment to the committee. Senator Lucas moved that the original bill be given an unfavorable report, a favorable report to the proposed committee substitute with the amendment incorporated into it. The motion passed.

Representative Womble presented his bill, HB 36, *Repeal Involuntary Sterilization*, to the committee. As it had been included in the agenda at the last minute, Senator Lucas moved that the bill be included in today's agenda. Senator Allran asked if the involuntary sterilization movement also included abortion. Ms. Dianna Jessup, staff research, replied that the research she had done so far indicated that abortion was not included. Senators Lucas and Kinnaird thanked Representative Womble for bringing this bill forward. Senator Malone moved that the bill be given a favorable report. The motion passed.

Senator Purcell asked Co-chair Bingham to preside while he explained his bill, SB 519, *Child Lead Poisoning Prevention Prg Amends.-AB*. He asked Ms. Linda Attarian, research staff. to provide further comments. Senator Allran asked about a fiscal note, Ms. Attarian responded that she could provide a fiscal note that had been made for a companion house bill, and copies were provided to the committee. Senator Forrester asked about imported toys painted with lead paint. Ed Norman of the Division of Environmental Health said there are federal agencies that watch for such toys as well as other products that may contain lead such as miniblinds. Senator Malone asked how much time is allotted for a lead paint clean up when reported. Mr. Norman responded that 14 days is allowed to begin a clean up, and 60 days for its completion, and added that lead paint has been banned since 1978. Senator Bingham asked for a motion to adopt a technical amendment, and Senator Lucas so moved. Senator Dannelly moved that the technical amendment be incorporated into a proposed committee substitute and that this be given a favorable report by the committee. The motion passed.

The meeting adjourned at 11:47 A.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, April 02, 2003

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

FAVORABLE

S.B. **507** Medicaid Cost Saving Measures.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

CORRECTED REPORT

Monday, April 07, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **522** Board of Nursing.

Draft Number:	PCS35232
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, April 02, 2003

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

FAVORABLE

H.B.(CS #1) **36** Repeal Involuntary Sterilization.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Monday, April 14, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **519** Child Lead Poisoning Prevention Prgm Amends.-AB

Draft Number:	PCS65246
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 507

Short Title:	Medicaid Cost Saving Measures.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health & Human Resources.	

March 24, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO USE AVAILABLE MEDICAID FUNDS FOR THE ISSUANCE OF MEDICAID IDENTIFICATION CARDS AND TO IMPLEMENT OTHER COST SAVING MEASURES.

The General Assembly of North Carolina enacts:

SECTION 1. Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, for the 2003-2004 fiscal year, the Department may use not more than seven hundred thousand dollars ($700,000) to implement plans to provide plastic magnetic stripped Medicaid identification cards for issuance to Medicaid enrollees. The Department shall identify available funds and develop and implement the identification card program as quickly as possible, but in a manner that maximizes cost savings in the Medical Assistance Program. Not later than July 1, 2004, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The report shall include the specific areas of the Medical Assistance Program from which funds were used, the corresponding amounts and anticipated or realized cost savings, and the implementation status of the identification card program.

SECTION 2. Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, for the 2003-2004 fiscal year, the Department may use available funds in addition to those authorized in Section 1 of this act to implement other cost savings projects or measures that are projected to result in recurring net cost savings and efficiencies. Prior to expending any funds under this section, the Department shall notify the Office of State Budget and Management, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division, and shall provide a complete explanation of the project or measures to be implemented, the estimated cost of implementation, and the projected

recurring cost savings and efficiencies expected to result from the expenditures. Within one year of the implementation of each project or measure authorized under this section, the Department shall report the actual implementation costs and actual net cost savings and efficiencies realized.

SECTION 3. This act becomes effective July 1, 2003.

SENATE BILL 507:
Medicaid Cost Saving Measures

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Sen. Rand
		Summary by:	Dianna Jessup
Date:	April 2, 2003		Committee Counsel
Version:	First Edition		

SUMMARY: ***Section 1 of Senate Bill 507 would authorize the Department of Health and Human Services (DHHS) to use not more than $700,000 of funds appropriated to it to implement plans to provide plastic magnetic stripped Medicaid identification cards for Medicaid enrollees in place of the paper cards currently mailed to enrollees each month. DHHS would be required to report on its implementation status of the program, the source of Medicaid funds used, and the corresponding amounts and anticipated or realized cost savings to the House and Senate Appropriations subcommittees on Health and Human Services and Fiscal Research by July 1, 2004.***

Section 2 would direct DHHS to use funds available to implement other cost savings projects or measures in the Medicaid program. Prior to expending funds under this Section, DHHS would have to notify the Office of State Budget, the House and Senate Appropriations subcommittees on Health and Human Services and Fiscal Research of the proposed projects or measures. Within one year of implementing a project or measure, DHHS would have to report the actual implementation costs and actual net cost savings and efficiencies realized.

The act would become effective July 1, 2003.

CURRENT LAW: The Division of Medical Assistance (DMA), DHHS, administers the State's Medicaid program. Currently, Medicaid enrollees use paper identification cards that are mailed to them each month. Medical providers use the information on the identification card to bill Medicaid. Approximately 1,000,000 paper Medicaid identification cards are mailed every month at a cost of $3.8 million annually (including printing and mailing).

North Carolina, like most other states, struggles with how to contain the cost of its Medicaid program. Last session, the General Assembly directed DHHS to contain Medicaid costs by undertaking certain activities, including adopting measures to reduce the rate of growth in the program and implementing a pharmacy management plan.

BILL ANALYSIS: If enacted, DMA would be to use up to $700,000 of funds appropriated to it during FY 03-04 to replace paper identification cards with plastic identification cards. It is anticipated by the Department that this would save $1 million a year in printing and mailing. Plastic magnetic stripped cards could be deactivated electronically. DHHS would be required to report on the implementation of the change to the House and Senate Appropriations subcommittees on Health and Human Services and Fiscal Research by July 1, 2004. In addition, the bill would authorize DHHS to use other available funds appropriated to it during FY 03-04 to implement cost savings and efficiencies in the Medicaid program.

507-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 522

Short Title:	Board of Nursing.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health & Human Resources.	

March 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE MEMBERS ON THE NORTH CAROLINA BOARD OF NURSING, TO CHANGE THE METHOD BY WHICH CERTAIN MEMBERS ARE ELECTED OR APPOINTED, TO MAKE TECHNICAL CHANGES TO THE NURSING PRACTICE ACT, AND TO REQUIRE THAT HEALTH CARE FACILITIES VERIFY THE LICENSURE STATUS OF APPLICANTS SEEKING EMPLOYMENT AS NURSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.21 reads as rewritten:

"**§ 90-171.21. Board of Nursing; composition; selection; vacancies; qualifications; term of office; compensation.**

(a) The Board shall consist of ~~15~~ 14 members. ~~Nine~~ Eight members shall be registered nurses. ~~Four~~ Three members shall be licensed practical nurses. ~~Two~~ Three members shall be representatives of the public.

(b) Selection. – The North Carolina Board of Nursing shall conduct an election each year to fill vacancies of nurse members of the Board scheduled to occur during the next year. Nominations of candidates for election of registered nurse members shall be made by written petition signed by not less than 10 registered nurses eligible to vote in the election. Nominations of candidates for election of licensed practical nurse members shall be made by written petition signed by not less than 10 licensed practical nurses eligible to vote in the election. Every licensed registered nurse holding an active license shall be eligible to vote in the election of registered nurse board members. Every licensed practical nurse holding an active license shall be eligible to vote in the election of licensed practical nurse board members. The list of nominations shall be filed with the Board after January 1 of the year in which the election is to be held and no later than midnight of the first day of April of such year. Before preparing ballots, the Board shall notify each person who has been duly nominated of his nomination and request permission to enter his name on the ballot. A member of the Board who is nominated to succeed himself and who does not withdraw his name from the ballot is disqualified to

participate in conducting the election. Elected members shall begin their term of office on January 1 of the year following their election.

Nominations of persons to serve as public members of the Board may be made to the Governor or the General Assembly by any citizen or group within the State. The Governor shall appoint ~~the two public members~~one public member to the ~~Board.~~Board, and the General Assembly shall appoint two public members to the Board in accordance with G.S. 120-121. One public member shall be appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives.

Board members shall be commissioned by the Governor upon their election or appointment.

(c) Vacancies. – All unexpired terms of Board members appointed by the General Assembly shall be filled in accordance with G.S. 120-122 and shall be filled within 45 days after the term is vacated. The Governor shall fill all other unexpired terms on the Board within 30 days after the term is vacated. For vacancies of registered nurse or licensed practical nurse members, the Governor shall appoint the person who received the next highest number of votes to those elected members at the most recent election for board members. ~~The Governor shall select the public member to fill any vacancy of a public member.~~ Appointees shall serve the remainder of the unexpired term and until their successors have been duly elected or appointed and qualified.

(d) Qualifications. – ~~Three of the registered nurse members shall hold positions with primary responsibility in nursing education and shall hold baccalaureate or advanced degrees. Six shall hold positions with primary responsibility in providing nursing care to patients. Of the six registered nurse members with primary responsibility in providing nursing care to patients, two shall be employed by a hospital and at least one shall be a hospital nursing service director; one shall be employed by a physician licensed to practice medicine in North Carolina and engaged in the private practice of medicine; one shall be employed by a skilled or intermediate care facility; one shall be either a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist; and one shall be a community health nurse. If no nurse is nominated in one of the categories, the position shall be an at-large registered nursing position.~~Of the eight registered nurse members on the Board, one shall be a nurse administrator employed by any type of nursing care delivery system where the nurse administrator is accountable for the administration of nursing services and not directly involved in patient care; one shall be an advanced practice registered nurse, defined as an individual who meets the requirements to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner; two shall be staff nurses, defined as individuals who are primarily involved in direct patient care regardless of practice setting; one shall be an at-large registered nurse who meets the requirements of sub-subdivisions (1)a. and b. of this subsection, but is not currently an educator in a program leading to licensure or any other degree-granting program; and three shall be nurse educators. Of the three nurse educators, one shall be a practical nurse educator, one shall be an associate degree or diploma nurse educator, and one shall be a

baccalaureate or higher degree nurse educator. All nurse educators shall meet the minimum education requirement as established by the Board's education program standards for nurse faculty. Candidates eligible for election to the Board as nurse educators are not eligible for election as the at-large member.

(1) ~~All~~ Except for the at-large member, all registered nurse members shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a registered nurse in North Carolina.

a1. Declare North Carolina as his or her primary State of residence.

b. Have ~~at least~~a minimum of five ~~years'~~ years of experience ~~in nursing practice, nursing administration, and/or nursing education.~~as a registered nurse.

c. Have been engaged continuously in ~~nursing practice, nursing administration, or nursing educationa~~ position that meets the criteria for the specified Board position for at least three years immediately preceding election.

d. Show evidence of the employer's awareness of the registered nurse's intent to serve on the Board.

(2) Licensed practical nurse members shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a licensed practical nurse in North Carolina.

a1. Declare North Carolina as his or her primary State of residence.

~~b. Be a graduate of a board-approved program for the preparation of practical nurses.~~

c. Have ~~at least~~a minimum of five ~~years'~~ years of experience as a licensed practical nurse.

d. Have been continuously engaged in the position of a licensed practical ~~nursing~~ nurse for at least three years immediately preceding election.

e. Show evidence of the employer's awareness of the licensed practical nurse's intent to serve on the Board.

(3) A public member shall not be a ~~health care~~ provider ~~nor the spouse of a health care provider. Public members shall reasonably represent the population of the State.~~of health services, employed in the health services field, or hold a vested interest at any level in the provision of health services as defined by the North Carolina Board of Ethics. No public member or person in the public member's immediate family as defined by G.S. 90-405(8) shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

(4) The nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist member shall be recognized by the Board as a registered nurse who meets the following criteria:

a. Has graduated from or completed a graduate level advanced practice nursing education program accredited by a national accrediting body.
b. Maintains current certification or recertification from a national credentialing body approved by the Board or meets other requirements established by rules adopted by the Board.
c. Practices in a manner consistent with rules adopted by the Board and other applicable law.

(e) Term. – ~~The term of office for board members shall be three years.~~Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive ~~three-year terms after July 1, 1981.~~four-year terms or eight consecutive years after January 1, 2005.

(f) Removal. – The Board may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Board business until the charges are resolved.

(g) Reimbursement. – Board members are entitled to receive compensation and reimbursement as authorized by G.S. 93B-5."

SECTION 2. G.S. 90-171.22 reads as rewritten:

"**§ 90-171.22. Officers.**

The officers of the Board shall be a chairman, ~~who shall be a registered nurse,~~ a vice-chairman, and ~~such~~ any other officers as the Board may deem necessary. All officers shall be elected annually by the Board for terms of one year and shall serve until their successors have been elected and qualified."

SECTION 3. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

...

(8) ~~Prescribe~~ Establish standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in G.S. 90-171.38.

(9) ~~Survey~~ Review all nursing programs at least every ~~five~~ eight years or more often as deemed necessary by the Board or program director.

...."

SECTION 4. G.S. 90-171.38(a) reads as rewritten:

"(a) A nursing program may be operated under the authority of a general hospital, or an approved post-secondary educational institution. The Board shall establish, revise, or repeal standards for nursing programs. These standards shall specify program requirements, curricula, faculty, students, facilities, resources, administration, and describe the approval process. Any institution desiring to establish a nursing program shall apply to the Board and submit satisfactory evidence that it will meet the standards ~~prescribed~~ established by the Board. Those standards shall be designed to ensure that graduates of those programs have the education necessary to safely and competently practice nursing. ~~The Board shall encourage the continued operation of all present programs that meet the standards approved by the Board.~~"

SECTION 5. G.S. 90-171.40 reads as rewritten:

"§ 90-171.40. ~~Periodic surveys.~~Ongoing approval.

The Board shall ~~designate persons to survey~~review all nursing programs in the State at least every ~~five~~ eight years or more often as deemed necessary. ~~Written reports of such surveys shall be submitted to the Board.~~ If the Board determines that any approved nursing program does not meet or maintain the standards required by the Board, notice thereof in writing specifying the deficiencies shall be given immediately to the institution responsible for the program. The Board shall withdraw approval from a program which fails to correct deficiencies within a reasonable time. The Board shall publish annually a list of nursing programs in this State showing their approval status."

SECTION 6. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-171.43A. Mandatory employer verification of licensure status.**

Before hiring a registered nurse or a licensed practical nurse in North Carolina, a health care facility, as defined in G.S. 131E-256(b), shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43. For purposes of this section, the term 'health care facility' includes public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 7. Members serving on the Board of Nursing on the effective date of this act shall continue to serve until December 31, 2004. To establish staggered terms for the appointments of public members made pursuant to G.S. 90-171.21(b), as enacted in Section 1 of this act, the Governor shall appoint one member for a four-year term, the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one member for a three-year term, and the General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one member for a two-year term.

To stagger terms for members elected to the Board, the Board shall conduct an election in 2004 pursuant to G.S. 90-171.21(b) to elect members as follows:

(1) An at-large registered nurse and a licensed practical nurse, each to serve for a one-year term.

(2) A staff registered nurse, a registered nurse who is an associate degree or diploma nurse educator, and a licensed practical nurse, each to serve for a two-year term.

(3) A registered nurse who is a baccalaureate or higher degree nurse educator, a registered nurse administrator, and a licensed practical nurse, each to serve for a three-year term.

(4) An advanced practice registered nurse, a staff registered nurse, and a registered nurse who is a practical nurse educator, each to serve for a four-year term.

All members appointed and elected to the Board pursuant to this section shall begin serving their terms on January 1, 2005. After staggered terms have been established, all subsequent appointments and elections to the Board shall be for four-year terms.

SECTION 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 522
PROPOSED COMMITTEE SUBSTITUTE S522-PCS35232-RP-1

Short Title: Board of Nursing. (Public)

Sponsors:

Referred to:

March 25, 2003

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE METHOD BY WHICH CERTAIN MEMBERS ON THE NORTH CAROLINA BOARD OF NURSING ARE ELECTED OR APPOINTED, TO MAKE TECHNICAL CHANGES TO THE NURSING PRACTICE ACT, AND TO REQUIRE THAT HEALTH CARE FACILITIES VERIFY THE LICENSURE STATUS OF APPLICANTS SEEKING EMPLOYMENT AS NURSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.21 reads as rewritten:

"**§ 90-171.21. Board of Nursing; composition; selection; vacancies; qualifications; term of office; compensation.**

(a) The Board shall consist of 15 members. Nine members shall be registered nurses. ~~Four~~ Three members shall be licensed practical nurses. ~~Two~~ Three members shall be representatives of the public.

(b) Selection. – The North Carolina Board of Nursing shall conduct an election each year to fill vacancies of nurse members of the Board scheduled to occur during the next year. Nominations of candidates for election of registered nurse members shall be made by written petition signed by not less than 10 registered nurses eligible to vote in the election. Nominations of candidates for election of licensed practical nurse members shall be made by written petition signed by not less than 10 licensed practical nurses eligible to vote in the election. Every licensed registered nurse holding an active license shall be eligible to vote in the election of registered nurse board members. Every licensed practical nurse holding an active license shall be eligible to vote in the election of licensed practical nurse board members. The list of nominations shall be filed with the Board after January 1 of the year in which the election is to be held and no later than midnight of the first day of April of such year. Before preparing ballots, the Board shall notify each person who has been duly nominated of ~~his~~ the person's nomination and request permission to enter ~~his~~ the person's name on the ballot. A member of the Board who is nominated ~~to succeed himself~~ for reelection and who does not withdraw ~~his~~ the

member's name from the ballot is disqualified to participate in conducting the election. Elected members shall begin their term of office on January 1 of the year following their election.

Nominations of persons to serve as public members of the Board may be made to the Governor or the General Assembly by any citizen or group within the State. The Governor shall appoint ~~the two public members~~one public member to the ~~Board.~~Board, and the General Assembly shall appoint two public members to the Board. Of the public members appointed by the General Assembly, one shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

Board members shall be commissioned by the Governor upon their election or appointment.

(c) Vacancies. – All unexpired terms of Board members appointed by the General Assembly shall be filled within 45 days after the term is vacated. The Governor shall fill all other unexpired terms on the Board within 30 days after the term is vacated. For vacancies of registered nurse or licensed practical nurse members, the Governor shall appoint the person who received the next highest number of votes to those elected members at the most recent election for board members. ~~The Governor shall select the public member to fill any vacancy of a public member.~~ Appointees shall serve the remainder of the unexpired term and until their successors have been duly elected or appointed and qualified.

(d) Qualifications. – ~~Three of the registered nurse members shall hold positions with primary responsibility in nursing education and shall hold baccalaureate or advanced degrees. Six shall hold positions with primary responsibility in providing nursing care to patients. Of the six registered nurse members with primary responsibility in providing nursing care to patients, two shall be employed by a hospital and at least one shall be a hospital nursing service director; one shall be employed by a physician licensed to practice medicine in North Carolina and engaged in the private practice of medicine; one shall be employed by a skilled or intermediate care facility; one shall be either a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist; and one shall be a community health nurse. If no nurse is nominated in one of the categories, the position shall be an at-large registered nursing position.~~Of the nine registered nurse members on the Board, two shall be nurse administrators, one employed by a hospital or a hospital system and one employed by any other type of nursing care delivery system, both of whom shall be accountable for the administration of nursing services and not directly involved in patient care; one shall be an advanced practice registered nurse, defined as an individual who meets the requirements to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner; two shall be staff nurses, defined as individuals who are primarily involved in direct patient care regardless of practice setting; one shall be an at-large registered nurse who meets the requirements of sub-subdivisions (1)a. and b. of this subsection, but is not currently an educator in a program leading to licensure or any other degree-granting program; and three shall be nurse educators. Of the three

nurse educators, one shall be a practical nurse educator, one shall be an associate degree or diploma nurse educator, and one shall be a baccalaureate or higher degree nurse educator. All nurse educators shall meet the minimum education requirement as established by the Board's education program standards for nurse faculty. Candidates eligible for election to the Board as nurse educators are not eligible for election as the at-large member.

(1) ~~All~~ Except for the at-large member, every registered nurse ~~members~~member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a registered nurse in North Carolina.

a1. Be a resident of North Carolina.

b. Have ~~at least~~a minimum of five ~~years'~~ years of experience ~~in nursing practice, nursing administration, and/or nursing education.~~as a registered nurse.

c. Have been engaged continuously in ~~nursing practice, nursing administration, or nursing educationa~~ position that meets the criteria for the specified Board position for at least three years immediately preceding election.

d. Show evidence that the employer of the registered nurse is aware that the nurse intends to serve on the Board.

(2) ~~Licensed~~ Every licensed practical nurse ~~members~~ member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a licensed practical nurse in North Carolina.

a1. Be a resident of North Carolina.

~~b. Be a graduate of a board approved program for the preparation of practical nurses.~~

c. Have ~~at least~~a minimum of five ~~years'~~ years of experience as a licensed practical nurse.

d. Have been engaged continuously in the position of a licensed practical ~~nursing~~ nurse for at least three years immediately preceding election.

e. Show evidence that the employer of the licensed practical nurse is aware that the nurse intends to serve on the Board.

(3) A public member shall not be a ~~health care~~ provider ~~nor the spouse of a health care provider. Public members shall reasonably represent the population of the State.~~of health services, employed in the health services field, or hold a vested interest at any level in the provision of health services as defined by the North Carolina Board of Ethics. No public member or person in the public member's immediate family as defined by G.S. 90-405(8) shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

(4) The nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist member shall be recognized by the Board as a registered nurse who meets the following criteria:

a. Has graduated from or completed a graduate level advanced practice nursing education program accredited by a national accrediting body.

b. Maintains current certification or recertification from a national credentialing body approved by the Board or meets other requirements established by rules adopted by the Board.

c. Practices in a manner consistent with rules adopted by the Board and other applicable law.

(e) Term. – ~~The term of office for board members shall be three years.~~Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive ~~three-year terms after July 1, 1981.~~four-year terms or eight consecutive years after January 1, 2005.

(f) Removal. – The Board may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Board business until the charges are resolved.

(g) Reimbursement. – Board members are entitled to receive compensation and reimbursement as authorized by G.S. 93B-5."

SECTION 2. G.S. 90-171.22 reads as rewritten:

"**§ 90-171.22. Officers.**

The officers of the Board shall be a ~~chairman,~~ chair, ~~who shall be a registered nurse,~~ a ~~vice-chairman,~~ vice-chair, and ~~such~~ any other officers ~~as~~ the Board ~~may deem~~ considers necessary. All officers shall be elected annually by the Board for terms of one year and shall serve until their successors have been elected and qualified."

SECTION 3. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

...

(8) ~~Prescribe~~ Establish standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in G.S. 90-171.38.

(9) ~~Survey~~ Review all nursing programs at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary by the Board or program director.

...."

SECTION 4. G.S. 90-171.38(a) reads as rewritten:

"(a) A nursing program may be operated under the authority of a general hospital, or an approved post-secondary educational institution. The Board shall establish, revise, or repeal standards for nursing programs. These standards shall specify program requirements, curricula, faculty, students, facilities, resources, administration, and describe the approval process. Any institution desiring to establish a nursing program shall apply to the Board and submit satisfactory evidence that it will meet the standards ~~prescribed~~ established by the Board. Those standards shall be designed to ensure that

graduates of those programs have the education necessary to safely and competently practice nursing. ~~The Board shall encourage the continued operation of all present programs that meet the standards approved by the Board.~~"

SECTION 5. G.S. 90-171.40 reads as rewritten:

"**§ 90-171.40. ~~Periodic surveys.~~Ongoing approval.**

The Board shall ~~designate persons to survey~~review all nursing programs in the State at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary. ~~Written reports of such surveys shall be submitted to the Board.~~ If the Board determines that any approved nursing program does not meet or maintain the standards required by the Board, the Board shall give written notice ~~thereof in writing~~ specifying the deficiencies ~~shall be given immediately~~ to the institution responsible for the program. The Board shall withdraw approval from a program ~~which~~ that fails to correct deficiencies within a reasonable time. The Board shall publish annually a list of nursing programs in this State showing their approval status."

SECTION 6. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-171.43A. Mandatory employer verification of licensure status.**

(a) Before hiring a registered nurse or a licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43.

(b) For purposes of this section, 'health care facility' means:

(1) Facilities described in G.S. 131E-256(b).

(2) Public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 7. Members serving on the Board of Nursing on the effective date of this act shall continue to serve until December 31, 2004. To establish staggered terms for the appointments of public members made pursuant to G.S. 90-171.21(b), as enacted in Section 1 of this act, the Governor shall appoint one member for a four-year term, the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one member for a three-year term, and the General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one member for a two-year term.

To stagger terms for members elected to the Board, the Board shall conduct an election in 2004 pursuant to G.S. 90-171.21(b) to elect members as follows:

(1) A registered nurse administrator employed by a hospital or hospital system, an at-large registered nurse, and a licensed practical nurse, each to serve for a one-year term.

(2) A staff registered nurse, a registered nurse who is an associate degree or diploma nurse educator, and a licensed practical nurse, each to serve for a two-year term.

(3) A registered nurse who is a baccalaureate or higher degree nurse educator, a registered nurse administrator employed by a nursing care delivery system other than a hospital system, and a licensed practical nurse, each to serve for a three-year term.

(4) An advanced practice registered nurse, a staff registered nurse, and a registered nurse who is a practical nurse educator, each to serve for a four-year term.

All members appointed and elected to the Board pursuant to this section shall begin serving their terms on January 1, 2005. After staggered terms have been established, all subsequent appointments and elections to the Board shall be for four-year terms.

SECTION 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 522
PROPOSED COMMITTEE SUBSTITUTE S522-CSRP-1 [v.3]

4/1/2003 11:29:22 AM

Short Title: Board of Nursing. (Public)

Sponsors:

Referred to:

March 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE MEMBERS ON THE NORTH CAROLINA BOARD OF NURSING, TO CHANGE THE METHOD BY WHICH CERTAIN MEMBERS ARE ELECTED OR APPOINTED, TO MAKE TECHNICAL CHANGES TO THE NURSING PRACTICE ACT, AND TO REQUIRE THAT HEALTH CARE FACILITIES VERIFY THE LICENSURE STATUS OF APPLICANTS SEEKING EMPLOYMENT AS NURSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.21 reads as rewritten:

"**§ 90-171.21. Board of Nursing; composition; selection; vacancies; qualifications; term of office; compensation.**

(a) The Board shall consist of ~~15~~ 14 members. ~~Nine~~ Eight members shall be registered nurses. ~~Four~~ Three members shall be licensed practical nurses. ~~Two~~ Three members shall be representatives of the public.

(b) Selection. – The North Carolina Board of Nursing shall conduct an election each year to fill vacancies of nurse members of the Board scheduled to occur during the next year. Nominations of candidates for election of registered nurse members shall be made by written petition signed by not less than 10 registered nurses eligible to vote in the election. Nominations of candidates for election of licensed practical nurse members shall be made by written petition signed by not less than 10 licensed practical nurses eligible to vote in the election. Every licensed registered nurse holding an active license shall be eligible to vote in the election of registered nurse board members. Every licensed practical nurse holding an active license shall be eligible to vote in the election of licensed practical nurse board members. The list of nominations shall be filed with the Board after January 1 of the year in which the election is to be held and no later than midnight of the first day of April of such year. Before preparing ballots, the Board shall notify each person who has been duly nominated of ~~his~~ the person's nomination and request permission to enter ~~his~~ the person's name on the ballot. A member of the Board

who is nominated ~~to succeed himself~~ for reelection and who does not withdraw ~~his~~ the member's name from the ballot is disqualified to participate in conducting the election. Elected members shall begin their term of office on January 1 of the year following their election.

Nominations of persons to serve as public members of the Board may be made to the Governor or the General Assembly by any citizen or group within the State. The Governor shall appoint ~~the two public members~~one public member to the ~~Board.~~Board, and the General Assembly shall appoint two public members to the Board. Of the public members appointed by the General Assembly, one shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

Board members shall be commissioned by the Governor upon their election or appointment.

(c) Vacancies. – All unexpired terms of Board members appointed by the General Assembly shall be filled within 45 days after the term is vacated. The Governor shall fill all other unexpired terms on the Board within 30 days after the term is vacated. For vacancies of registered nurse or licensed practical nurse members, the Governor shall appoint the person who received the next highest number of votes to those elected members at the most recent election for board members. ~~The Governor shall select the public member to fill any vacancy of a public member.~~ Appointees shall serve the remainder of the unexpired term and until their successors have been duly elected or appointed and qualified.

(d) Qualifications. – ~~Three of the registered nurse members shall hold positions with primary responsibility in nursing education and shall hold baccalaureate or advanced degrees. Six shall hold positions with primary responsibility in providing nursing care to patients. Of the six registered nurse members with primary responsibility in providing nursing care to patients, two shall be employed by a hospital and at least one shall be a hospital nursing service director; one shall be employed by a physician licensed to practice medicine in North Carolina and engaged in the private practice of medicine; one shall be employed by a skilled or intermediate care facility; one shall be either a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist; and one shall be a community health nurse. If no nurse is nominated in one of the categories, the position shall be an at-large registered nursing position.~~Of the eight registered nurse members on the Board, one shall be a nurse administrator employed by any type of nursing care delivery system where the nurse administrator is accountable for the administration of nursing services and not directly involved in patient care; one shall be an advanced practice registered nurse, defined as an individual who meets the requirements to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner; two shall be staff nurses, defined as individuals who are primarily involved in direct patient care regardless of practice setting; one shall be an at-large registered nurse who meets the requirements of sub-subdivisions (1)a. and b. of this subsection, but is not currently an educator in a program leading to licensure or any other degree-granting program; and three shall be

nurse educators. Of the three nurse educators, one shall be a practical nurse educator, one shall be an associate degree or diploma nurse educator, and one shall be a baccalaureate or higher degree nurse educator. All nurse educators shall meet the minimum education requirement as established by the Board's education program standards for nurse faculty. Candidates eligible for election to the Board as nurse educators are not eligible for election as the at-large member.

(1) ~~All~~ Except for the at-large member, every registered nurse ~~members~~member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a registered nurse in North Carolina.

a1. Be a resident of North Carolina.

b. Have ~~at least~~a minimum of five ~~years'~~ years of experience ~~in nursing practice, nursing administration, and/or nursing education.~~as a registered nurse.

c. Have been engaged continuously in ~~nursing practice, nursing administration, or nursing educationa~~ position that meets the criteria for the specified Board position for at least three years immediately preceding election.

d. Show evidence that the employer of the registered nurse is aware that the nurse intends to serve on the Board.

(2) ~~Licensed~~ Every licensed practical nurse ~~members~~ member shall meet the following criteria:

a. Hold a ~~current~~ current, unencumbered license to practice as a licensed practical nurse in North Carolina.

a1. Be a resident of North Carolina.

~~b. Be a graduate of a board approved program for the preparation of practical nurses.~~

c. Have ~~at least~~a minimum of five ~~years'~~ years of experience as a licensed practical nurse.

d. Have been engaged continuously in the position of a licensed practical ~~nursing~~ nurse for at least three years immediately preceding election.

e. Show evidence that the employer of the licensed practical nurse is aware that the nurse intends to serve on the Board.

(3) A public member shall not be a ~~health care~~ provider ~~nor the spouse of a health care provider. Public members shall reasonably represent the population of the State.~~of health services, employed in the health services field, or hold a vested interest at any level in the provision of health services as defined by the North Carolina Board of Ethics. No public member or person in the public member's immediate family as defined by G.S. 90-405(8) shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

(4) The nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist member shall be recognized by the Board as a registered nurse who meets the following criteria:

a. Has graduated from or completed a graduate level advanced practice nursing education program accredited by a national accrediting body.

b. Maintains current certification or recertification from a national credentialing body approved by the Board or meets other requirements established by rules adopted by the Board.

c. Practices in a manner consistent with rules adopted by the Board and other applicable law.

(e) Term. – ~~The term of office for board members shall be three years.~~Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive ~~three-year terms after July 1, 1981.~~four-year terms or eight consecutive years after January 1, 2005.

(f) Removal. – The Board may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Board business until the charges are resolved.

(g) Reimbursement. – Board members are entitled to receive compensation and reimbursement as authorized by G.S. 93B-5."

SECTION 2. G.S. 90-171.22 reads as rewritten:

"**§ 90-171.22. Officers.**

The officers of the Board shall be a ~~chairman,~~ chair, ~~who shall be a registered nurse,~~ a ~~vice-chairman,~~ vice-chair, and ~~such~~ any other officers ~~as~~ the Board ~~may deem~~ considers necessary. All officers shall be elected annually by the Board for terms of one year and shall serve until their successors have been elected and qualified."

SECTION 3. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

...

(8) ~~Prescribe~~ Establish standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in G.S. 90-171.38.

(9) ~~Survey~~ Review all nursing programs at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary by the Board or program director.

...."

SECTION 4. G.S. 90-171.38(a) reads as rewritten:

"(a) A nursing program may be operated under the authority of a general hospital, or an approved post-secondary educational institution. The Board shall establish, revise, or repeal standards for nursing programs. These standards shall specify program requirements, curricula, faculty, students, facilities, resources, administration, and describe the approval process. Any institution desiring to establish a nursing program shall apply to the Board and submit satisfactory evidence that it will meet the standards ~~prescribed~~ established by the Board. Those standards shall be designed to ensure that

graduates of those programs have the education necessary to safely and competently practice nursing. ~~The Board shall encourage the continued operation of all present programs that meet the standards approved by the Board.~~"

SECTION 5. G.S. 90-171.40 reads as rewritten:

"**§ 90-171.40. ~~Periodic surveys.~~Ongoing approval.**

The Board shall ~~designate persons to survey~~review all nursing programs in the State at least every ~~five~~ eight years or more often as ~~deemed~~ considered necessary. ~~Written reports of such surveys shall be submitted to the Board.~~ If the Board determines that any approved nursing program does not meet or maintain the standards required by the Board, the Board shall give written notice ~~thereof in writing~~ specifying the deficiencies ~~shall be given immediately~~ to the institution responsible for the program. The Board shall withdraw approval from a program ~~which~~ that fails to correct deficiencies within a reasonable time. The Board shall publish annually a list of nursing programs in this State showing their approval status."

SECTION 6. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-171.43A. Mandatory employer verification of licensure status.**

(a) Before hiring a registered nurse or a licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43.

(b) For purposes of this section, 'health care facility' means:

(1) Facilities described in G.S. 131E-256(b).

(2) Public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 7. Members serving on the Board of Nursing on the effective date of this act shall continue to serve until December 31, 2004. To establish staggered terms for the appointments of public members made pursuant to G.S. 90-171.21(b), as enacted in Section 1 of this act, the Governor shall appoint one member for a four-year term, the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one member for a three-year term, and the General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one member for a two-year term.

To stagger terms for members elected to the Board, the Board shall conduct an election in 2004 pursuant to G.S. 90-171.21(b) to elect members as follows:

(1) An at-large registered nurse and a licensed practical nurse, each to serve for a one-year term.

(2) A staff registered nurse, a registered nurse who is an associate degree or diploma nurse educator, and a licensed practical nurse, each to serve for a two-year term.

(3) A registered nurse who is a baccalaureate or higher degree nurse educator, a registered nurse administrator, and a licensed practical nurse, each to serve for a three-year term.

(4) An advanced practice registered nurse, a staff registered nurse, and a registered nurse who is a practical nurse educator, each to serve for a four-year term.

All members appointed and elected to the Board pursuant to this section shall begin serving their terms on January 1, 2005. After staggered terms have been established, all subsequent appointments and elections to the Board shall be for four-year terms.

SECTION 8. This act is effective when it becomes law.

SENATE BILL 522: Board of Nursing

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Sen. Rand
Date:	April 2, 2003	**Summary by:**	Amy Compeau
Version:	PCS for 1st Edition S522-CSRP-1		Research Division Staff

SUMMARY: Senate Bill 522 would: (1) require health care facilities to verify the licensure status of applicants seeking employment as nurses, (2) reduce the membership of the Board of Nursing, (3) change the method by which certain members are elected or appointed, and (4) make other technical changes to the Nursing Practice Act. The act would become effective when it becomes law. The proposed Senate committee substitute makes technical and clarifying changes to the original bill.

BACKGROUND AND BILL ANALYSIS:

Mandatory Employer Verification of Licensure Status

According to the NC Board of Nursing (Board), the Board maintains a licensure database that is updated every 24 hours. Free access is available to the database via a web-based or automated telephone verification system. Section 6 of SB 522 would require employers in health care facilities to verify the licensure status of a registered nurse (RN) or a licensed practical nurse (LPN) before hiring the applicant. The employers could access the Board's licensure database to verify licensure as required under this section.

DEFINITION OF "HEALTH CARE FACILITY": G.S. 131E-256(b) defines the term, "health care facility" to include: (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 (9) 24-hour facilities. In addition, SB 522 would consider the following to be a "health care facility": (1) public health departments, (2) physicians' offices, (3) ambulatory care facilities, and (4) rural health clinics.

Currently, Article 15 of Chapter 131E of the General Statutes requires health care facilities to access the Health Care Personnel Registry (Registry) before hiring certain health care personnel including nurse aides, in-home aides, adult care personal aides, and unlicensed assistant personnel. The Registry contains the names of personnel who were subject to findings of neglect or abuse, misappropriation of resident or facility property and other offenses.

Changes to Board Membership and Terms

Changes to Board Membership		
	Current Law	**SB 522**
# of RNs on Board	9	8
# of LPNs on Board	4	3
# of Public Members on Board	2	3
Total Board Membership	**15**	**14**
Changes to Appointment and Selection of Board Members		
# of Public Members Appointed by the Governor	2	1
# of Public Members Appointed by the General Assembly	0	2 (1 upon rec. of Pres. Pro. Tem and 1 upon rec. of Speaker)
Changes to Terms and Term Limits		
Length of Terms	3 years	4-year staggered
Term Limits	No more than two consecutive 3-year terms	No more than two consecutive 4-year terms or 8 consecutive years

Changes to Qualifications for RN Board Members

Changes to Qualification Criteria for RN Board Members	
Current Law*	**SB 522**
3 Nurse Educators who hold baccalaureate or advanced degrees	**3** Nurse Educators as follows: (1) practical nurse educator, (1) associate degree or diploma nurse educator, and (1) baccalaureate or higher degree nurse educator
2 RNs employed by a hospital, with at least one being a hospital nursing service director	**2** Staff Nurses
1 employed by a licensed physician in private practice	**1** Nurse Administrator
1 employed by a skilled or intermediate care facility	**1** At-Large Member
1 shall be either a (1) nurse practitioner, (2) nurse anesthetist, (3) nurse midwife, or (4) clinical nurse specialist	**1** Advanced Practice Registered Nurse
1 community health nurse	
Total of 9 RN Members	**Total of 8 RN Members**

*** Current law does allow for an at-large registered nursing position on the Board, if no nurse is nominated in one of the existing categories.**

Other Changes Affecting Board Membership

SB522 would require the RN members of the Board, except for the at-large member, and the LPN members of the Board to be residents of the state of North Carolina and to show evidence of the employer's awareness of the nurse's intent to serve on the Board.

The bill would clarify that a public member shall not be: (1) a provider of health services, (2) employed in the health services field, or (3) hold a vested interest at any level in the provision of health services. Furthermore, no public member or person in the public member's immediate family shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

The bill would delete limitations by which Board members may serve as officers of the Board. Under current law, only a RN may serve as chair.

Board's Review of Nursing Programs

According to the Board, there are 95 approved education programs for initial licensure of registered nurses or licensed practical nurses in the State. Current law requires all nursing programs to be reviewed by the Board for approval status at least every 5 years. SB 522 would change the requirement for review to at least every 8 years.

Transition from Current Board Status and Membership

Members serving on the Board on the effective date of this act would continue to serve until December 31, 2004. SB 522 would establish methods for staggered terms for the appointments of public members and for the election of elected members. All members appointed and elected to the Board would begin serving their terms on January 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 36

Committee Substitute Favorable 3/19/03

Short Title: Repeal Involuntary Sterilization. (Public)

Sponsors:

Referred to:

February 19, 2003

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE LAW THAT AUTHORIZES THE INVOLUNTARY STERILIZATION OF PERSONS WHO ARE MENTALLY ILL OR MENTALLY RETARDED, TO PERMIT THE STERILIZATION OF MENTALLY ILL OR MENTALLY RETARDED WARDS ONLY WHEN THERE IS A MEDICAL NECESSITY, AND TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

PART I. REPEALS THE LAW AUTHORIZING INVOLUNTARY STERILIZATIONS AND PERMITS THE STERILIZATION OF MENTALLY ILL OR MENTALLY RETARDED WARDS ONLY WHEN THERE IS A MEDICAL NECESSITY.

SECTION 1. Article 7 of Chapter 35 of the General Statutes is repealed.

SECTION 1.(a) Article 8 of Chapter 35A is amended by adding a new section to read:

"**§ 35A-1245. Procedure to permit the sterilization of a mentally ill or a mentally retarded ward in the case of medical necessity.**

(a) A guardian of the person shall not consent to the sterilization of a mentally ill or mentally retarded ward unless an order from the clerk has been obtained in accordance with this section.

(b) If a mentally ill or mentally retarded ward needs to undergo a medical procedure that would result in sterilization, the ward's guardian shall petition the clerk for an order to permit the guardian to consent to the procedure. The petition shall contain the following:

(1) A sworn statement from a physician licensed in this State who has examined the ward that the proposed procedure is medically necessary and not for the sole purpose of sterilization or for the purpose of hygiene or convenience.

(2) The name and address of the physician who will perform the procedure.

(3) A sworn statement from a psychiatrist or psychologist licensed in this State who has examined the ward as to whether the mentally ill or mentally retarded ward is able to comprehend the nature of the proposed procedure and its consequences and provide an informed consent to the procedure.

(4) If the ward is able to comprehend the nature of the proposed procedure and its consequences, the sworn consent of the ward to the procedure.

(c) A copy of the petition shall be served on the ward personally. If the ward is unable to comprehend the nature of the proposed procedure and its consequences and is unable to provide an informed consent, the clerk shall appoint an attorney to represent the ward.

(d) Should the ward or the ward's attorney request a hearing, a hearing shall be held. Otherwise, the clerk may enter an order without the appearance of witnesses. If a hearing is held, the guardian and the ward may present evidence.

(e) If the clerk finds the following, the clerk shall enter an order permitting the guardian to consent to the proposed procedure:

(1) The ward is capable of comprehending the procedure and its consequences and has consented to the procedure, or the ward is unable to comprehend the procedure and its consequences.

(2) The procedure is medically necessary and is not solely for the purpose of sterilization or for hygiene or convenience.

(f) The guardian or the ward, the ward's attorney, or any other interested party may appeal the clerk's order to the superior court in accordance with G.S. 1-301.2(e)."

PART II. CONFORMING CHANGES TO THE GENERAL STATUTES.

SECTION 2. G.S. 1-301.2(g) reads as rewritten:

"(g) Exception for Incompetency and Foreclosure ~~Proceedings.~~Proceedings and Proceedings to Permit Sterilization for Medical Necessity. –

(1) Proceedings for adjudication of incompetency or restoration of competency under Chapter 35A of the General ~~Statutes~~ Statutes, or proceedings to determine whether a guardian may consent to the sterilization of a mentally ill or mentally retarded ward under G.S. 35A-1245, shall not be transferred even if an issue of fact, an equitable defense, or a request for equitable relief is raised. Appeals from orders entered in these proceedings are governed by Chapter 35A to the extent that the provisions of that Chapter conflict with this section.

(2) Foreclosure proceedings under Article 2A of Chapter 45 of the General Statutes shall not be transferred even if an issue of fact, an equitable defense, or a request for equitable relief is raised. Equitable issues may be raised only as provided in G.S. 45-21.34. Appeals from orders entered in these proceedings are governed by Article 2A of Chapter 45 to the extent that the provisions of that Article conflict with this section."

SECTION 2.(a) G.S. 7A-451(a)(10) is repealed.

SECTION 3. G.S. 35A-1203(e) reads as rewritten:

"(e) Where a guardian or trustee has been appointed for a ward under former Chapter 33 or former Chapter 35 of the General Statutes, the clerk, upon his own motion or the motion of that guardian or trustee or any other interested person, may designate that guardian or trustee or appoint another qualified person as guardian of the person, guardian of the estate, or general guardian of the ward under this Chapter; provided, the authority of a guardian or trustee properly appointed under former Chapter 33 or former Chapter 35 of the General Statutes to continue serving in that capacity is not dependent on such motion and designation."

SECTION 4. G.S. 35A-1241(a) reads as rewritten:

"(a) To the extent that it is not inconsistent with the terms of any order of the clerk or any other court of competent jurisdiction, a guardian of the person has the following powers and duties:

(1) The guardian of the person is entitled to custody of the person of ~~his~~the guardian's ward and shall make provision for ~~his~~the ward's care, comfort, and maintenance, and shall, as appropriate to the ward's needs, arrange for ~~his~~ the ward's training, education, employment, rehabilitation or habilitation. The guardian of the person shall take reasonable care of the ward's clothing, furniture, vehicles, and other personal effects that are with the ward.

(2) The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State if in-State and out-of-State places are substantially equivalent. ~~He~~ The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, ~~he~~the guardian shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.

(3) The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service. ~~He~~ The guardian ~~may~~ shall not, however, consent to the sterilization of a mentally ill or mentally retarded ~~ward. Such sterilization may be performed only after compliance with Chapter 35, Article 7.~~ ward unless the guardian obtains an order from the clerk in accordance with G.S. 35A-1245. The guardian of the person may give any other consent or approval on the ward's behalf that may be required or in the ward's best interest. ~~He~~The guardian may petition the clerk for the clerk's concurrence in the consent or approval."

SECTION 5. G.S. 90-21.13(e) reads as rewritten:

"(e) In the event of any conflict between the provisions of this section and those of ~~Article 7 of Chapter 35 and~~ G.S. 35A-1245 and Articles 1A and 19 of Chapter 90, the provisions of those Articles shall control and continue in full force and effect."

SECTION 6. G.S. 90-275 reads as rewritten:

"**§ 90-275. Article does not affect ~~eugenical or therapeutical sterilization laws.~~duty of guardian to obtain order permitting guardian to consent to sterilization of a mentally ill or mentally retarded ward.**

Nothing in this Article shall be deemed to affect the provisions of ~~Article 7 of Chapter 35 of the General Statutes of North Carolina.~~ G.S. 35A-1245."

SECTION 7. G.S. 108A-14(a)(10) is repealed.

SECTION 8. G.S. 148-22.2 reads as rewritten:

"**§ 148-22.2. Procedure when surgical operations on inmates are necessary.**

The medical staff of any penal institution of the State of North Carolina is hereby authorized to perform or cause to be performed by competent and skillful surgeons surgical operations upon any inmate when such operation is necessary for the improvement of the physical condition of the inmate. The decision to perform ~~such~~an operation shall be made by the chief medical officer of the institution, with the approval of the superintendent of the institution, and with the advice of the medical staff of ~~said~~ the institution. No ~~such~~operation shall be performed without the consent of the inmate; or, if the inmate ~~be~~is a minor, without the consent of a responsible member of ~~his~~the inmate's family, a guardian, or one having legal custody of ~~such~~the minor; or, if the inmate be non compos mentis, then the consent of a responsible member of ~~his~~the inmate's family or of a guardian ~~must~~shall be obtained. Any surgical operations on inmates of State penal institutions shall also be subject to the provisions of Article 1A of Chapter 90 of the General Statutes and G.S. 90-21.13 and G.S. 90-21.14.

If the operation on the inmate is determined by the chief medical officer to be an emergency situation in which immediate action is necessary to preserve the life or health of the inmate, and the inmate, if sui juris, is unconscious or otherwise incapacitated so as to be incapable of giving consent or in the case of a minor or inmate non compos mentis, the consent of a responsible member of ~~his~~the inmate's family, guardian, or one having legal custody of ~~such~~the inmate cannot be obtained within the time necessitated by the nature of the emergency situation, then the decision to proceed with the operation shall be made by the chief medical officer and the superintendent of the institution with the advice of the medical staff of the institution.

In all cases falling under this Article [section], the chief medical officer of the institution and the medical staff of the institution shall keep a careful and complete record of the measures taken to obtain the permission for ~~such~~the operation and a complete medical record signed by the medical superintendent or director, the surgeon performing the operation and all surgical consultants of the operation performed.

~~This Article [section] is not to be considered as affecting the provisions of Article 7 of Chapter 35 of the General Statutes dealing with eugenical sterilization.~~"

SECTION 9. This act is effective when it becomes law and applies to all petitions for sterilization pending and orders authorizing sterilization that have not been executed as of the effective date of this act.

HOUSE BILL 36:
Repeal Involuntary Sterilization

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Reps. Womble, Luebke, Weiss, Insko
Date:	April 2, 2003	**Summary by:**	Dianna Jessup Committee Counsel
Version:	Second Edition		

SUMMARY: Part I of House Bill 36 would repeal the procedure that authorizes the sterilization of a mentally ill or a mentally retarded individual, whether or not the individual wishes to be sterilized, upon a petition filed in district court and an order entered by a district court judge. Guardians could obtain permission of the court to consent to a medically necessary procedure that would result in the sterilization of a mentally ill or mentally retarded ward. Part II of the bill would make conforming changes to the General Statutes. Consenting minors (upon order from a juvenile court) and adults would continue to be able to seek sterilization. The bill would become effective when it becomes law.

CURRENT LAW: Under Article 7 of Chapter 35 of the General Statutes (G.S. 35-36 through 35-50), certain persons can request an order from the district court to authorize the sterilization of a mentally ill or mentally retarded person.[1] In the case of an institutionalized mentally ill or mentally retarded person, the parent or guardian of the person or the director of the institution may make the request. In the case of a person who is not a resident of an institution, the parent or guardian of the person or the county director of social services may make the request. G.S. 35-29 makes it the duty of the petitioner to initiate sterilization proceedings under any of the following circumstances:

1) When it is in the best interest of the mental, moral, or physical improvement of the person to be sterilized.

2) When it is for the public good that the person be sterilized.

3) When the person would be likely, unless sterilized, to procreate a child who would have a tendency to serious physical, mental, or nervous disease or deficiency; or, because of a physical, mental, or nervous disease or deficiency which is not likely to materially improve, the person would be unable to care for a child.

The request to sterilize is initiated by the filing of a petition in district court. Under G.S. 35-40, the petition must contain the following:

- Allegations of the results of psychological or psychiatric tests supporting the assertion that the person is subject to the provisions of the statute.
- The statement of a physician who has examined the person who is the subject of the petition affirming whether or not there is any known contraindication to the sterilization procedure.
- The name and address of the physician who will perform the sterilization.

[1] "Mentally ill" and "mentally retarded" are not defined in Article 7 of Chapter 35. However, the mental health statutes (G.S. 122C-3) define "mental illness" "(i) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control; and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is in need of treatment" and "mental retardation" as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before age 22".

- The written consent or objection of the next of kin or the legal guardian. If there is no next of kin or legal guardian, the court must appoint a guardian ad litem to investigate and report to the court.
- The consent or objection or the person who is the subject of the petition. If the person is incapable of consenting or objecting, the petitioner must certify that the procedure has been explained to the person.

A copy of the petition must be served on the person who is the subject of the petition and on the legal or natural guardian[2] or next of kin of the person who is the subject of the petition. If the petitioner is someone other than the county director of social services, the judge must order the county director of social services in the county in which the person who is the subject of the petition resides to investigate and make recommendations to the court regarding the case. The person who is the subject of the petition has the right to counsel at all stages of the proceedings. If the petitioner, the person who is the subject of the petition, or any other interested party requests a hearing, a hearing must be held. In the absence of written objection filed by the subject of the petition or other interested party, the court may render judgment without the appearance of witnesses. If a hearing is requested, the district attorney may present the evidence for the petitioner. The person who is the subject of the petition is entitled to present evidence and cross-examine witnesses.

The law expressly authorizes the court to enter an order of sterilization of a mentally ill or mentally retarded person based upon either of two grounds. The first ground is if the person would probably be unable to care for a child or children. The second ground is if the person would be likely, unless sterilized, to procreate a child or children who probably would have serious physical, mental, or nervous diseases or deficiencies. In addition, the appellate courts have interpreted the statute to require the district court to find (based on clear, strong, and convincing evidence) that the person is physically capable of procreation, that there is a substantial likelihood that the person will voluntarily or otherwise engage in sexual activity likely to cause impregnation, that the person is unable or unwilling to control procreation by birth control or contraceptive methods, and that the proposed method of sterilization entails the least invasion of the person's body.

Article 7 of Chapter 35 of the General Statutes has withstood constitutional challenges, based on both substantive and procedural grounds.

Article 19 of Chapter 90 of the General Statutes permits a physician to perform a sterilization operation 1) upon a person over 18 when requested by the person in writing or 2) upon a minor when requested in writing by the minor, provided that a juvenile court determines the operation is in the best interest of the minor.

A guardian of the person may not consent to the sterilization of a mentally ill or mentally retarded ward unless the current procedure in Chapter 35 is followed.[3]

BILL ANALYSIS: If the bill is enacted, the statutory procedure for involuntary sterilizations would be repealed. Adults and married minors could still request a physician to perform a sterilization procedure. A minor, upon a finding by a juvenile court that it is in the minor's best interest, could also be sterilized if the minor so chooses. The bill would also make the necessary conforming changes to the General Statutes.

---

[2] Parents are considered the natural guardians of their children. G.S. 35A-1201(a)(6).
[3] G.S. 35A-1215; G.S. 35A-1241(a)(3).

In the second edition, Section 1.(a). was added. This section would amend Chapter 35A (the guardianship statutes) to provide a procedure to permit the sterilization of a mentally ill or a mentally retarded ward in the case of medical necessity. Under the provision, a guardian of the person would not be able to consent to the sterilization of a mentally ill or mentally retarded ward unless the guardian obtains an order from the clerk of court that permits the guardian to do so. To obtain the order, the guardian would have to file a petition that contains the following:

1. A sworn statement from a physician licensed in this State who has examined the ward that the proposed procedure is medically necessary and not for the sole purpose of sterilization or for the purpose of hygiene or convenience.
2. The name and address of the physician who will perform the procedure.
3. A sworn statement from a psychiatrist or psychologist licensed in this State who has examined the ward as to whether the ward is able to comprehend the nature of the proposed procedure and its consequences and is able to give an informed consent to the procedure. If the psychiatrist indicates that the ward is capable of consenting to the procedure, the petition must contain the ward's sworn consent.

A copy of the petition would have to be served on the ward, and an attorney would be appointed to represent the ward if the ward is unable to comprehend the nature and consequences of the procedure and provide an informed consent. If the ward or the ward's attorney requests a hearing, one would have to be held – otherwise, the clerk could rule without a hearing. If the clerk were to find **either** that the ward is capable of consenting to the procedure and consents to it, **or** the ward is unable to comprehend the procedure and its consequences, **and** the procedure is medically necessary, the clerk would have to enter an order permitting the guardian to consent to the procedure. The clerk's order could be appealed to the Superior Court.

BACKGROUND:

Brief History of Eugenics Movement: "Eugenics" is defined as the study of methods of improving genetic qualities by selective breeding. During the early part of the 20th century, social reformers advocated eugenic sterilization as a solution to problems such as mental retardation. In 1907, Indiana was the first state to pass a eugenic sterilization program, and California followed in 1909. More than 30 states eventually enacted these laws. North Carolina's eugenics law was passed in 1929 and was rewritten in 1933. It created a Eugenics Board to review petitions for sterilization. The law authorized sterilizations for three reasons: (1) epilepsy, (2) mental disease, and (3) feeblemindedness. Because record keeping varied from state to state, the exact number of eugenic sterilizations performed in the United States may never be known. Researchers *estimate* that about 65,000 people were sterilized. More than 7,600 people were sterilized in North Carolina between 1929 and 1974. North Carolina ranked third after Virginia with about 8,000 sterilizations and California with 21,000 sterilizations. Whereas most states sharply curtailed their sterilization programs after World War II, nearly four-fifths of sterilizations in North Carolina were done after 1945. By the late 1960s, more than 60% of those sterilized in North Carolina were black, and 99% were female. The Eugenics Board was abolished in 1974, and the current process for obtaining an order to sterilize a mentally ill or mentally retarded person was put into place.

Eugenics Board of North Carolina: The Board consisted of five members as follows:

1. The Commissioner of Public Welfare
2. The Secretary of the State Board of Health
3. The Chief Medical Officer at the State Hospital in Raleigh
4. The Chief Medical Officer of an institution for the feebleminded or insane from an institution outside of Raleigh
5. A representative from the Attorney General's Office

These five members met in a conference room in Raleigh, where they worked through about 30 cases per month, determining whether people should or should not be sterilized. Sterilization was ordered in more than 90% of the cases before the Board.

Lawsuits/Cases: In *Buck v. Bell* (1927), the United States Supreme Court set a precedent allowing the sterilization of the "feebleminded." There have never been any successful lawsuits over eugenic sterilizations in the U.S. North Carolina is the first state to ever consider paying reparations to victims of a eugenic sterilization program.

How States are Making Amends: The governors of the following Virginia, Oregon, North Carolina, and South Carolina have issued apologies for forced sterilizations. In addition to issuing a public apology, Governor Easley established a committee to investigate the eugenics program and consider reparations or counseling services for victims. The committee is chaired by the Secretary of the Department of Health and Human Services (DHHS) and consists of the following members:

- General counsel from DHHS;
- A representative from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS; and
- Two representatives from the Department of Cultural Resources.

State Laws Regulating Sterilization: **11** states have laws that allow certain parties to petition the court for involuntary sterilization of the mentally ill, including: Colorado, Connecticut, Delaware, Georgia, Maine, Minnesota, Mississippi, North Carolina, Vermont, Virginia, and West Virginia.

More information regarding North Carolina's eugenic sterilization program is available at the link, http://againsttheirwill.journalnow.com/. This link will take you to a series of articles published by the Winston Salem Journal.

Amy Compeau, Research Assistant, contributed to this summary. *H36-SMSW-002*

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 522

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

S522-ARP-1 [v.1]

Date _____,2003

Comm. Sub. [YES]
Amends Title [NO]
S522-CSRP-1 [v.3]

Senator _____

moves to amend the bill on page 1, line 12, by rewriting the line to read:

"The Board shall consist of 15 members. Nine members shall be"; and

on page 2, lines 34-37, by rewriting the lines to read:

"~~categories, the position shall be an at-large registered nursing position~~. Of the nine registered nurse members on the Board, two shall be nurse administrators, one employed by a hospital or a hospital system and one employed by any other type of nursing care delivery system, both of whom shall be accountable for the administration of nursing services and not directly involved in patient care; one"; and

on page 5, lines 35-36, by rewriting the lines to read:

"(1) A registered nurse administrator employed by a hospital or hospital system, an at-large registered nurse, and a licensed practical nurse, each to serve for a one-year term."; and

on page 5, lines 33-35 by rewriting the lines to read:

"(3) A registered nurse who is a baccalaureate or higher degree nurse educator, a registered nurse administrator employed by a nursing care delivery system other than a hospital system, and a licensed practical nurse, each to serve for a three-year term.".

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 522

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

S522-ARP-1 [v.1]

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 519*

Short Title:	Child Lead Poisoning Prevention Prgm Amends.-AB	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health & Human Resources.	

March 24, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-131.7 reads as rewritten:

"**§ 130A-131.7. Definitions.**

~~As used in this Part, unless the context requires otherwise, the term:~~The following definitions apply in this Part:

(1) "Abatement" means undertaking any of the following measures to eliminate a lead-based paint hazard:
   a. Removing lead-based paint from a surface and repainting the surface.
   b. Removing a component, such as a windowsill, painted with lead-based paint and replacing the component.
   c. Enclosing a surface painted with lead-based paint with paneling, vinyl siding, or another approved material.
   d. Encapsulating a surface painted with lead-based paint with a sealant.
   e. Any other measure approved by the Commission.

(2) "Child-occupied facility" means a building, or portion of a building, constructed ~~prior to~~before 1978, regularly visited by a child who is less than ~~6~~ six years of age. Child-occupied facilities may include, but are not limited to, child care facilities, preschools, nurseries, kindergarten classrooms, schools, clinics, or treatment centers including the common areas, the grounds, any outbuildings, or other structures appurtenant to the facility.

(3) "Confirmed lead poisoning" means a blood lead concentration of 20 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(4) "Department" means the Department of Environment and Natural Resources or its authorized agent.

(5) "Elevated blood lead level" means a blood lead concentration of 10 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(6) "Lead-based paint hazard" means a condition that is likely to ~~cause adverse health effects as a~~ result ~~of~~ in exposure to lead-based paint or to soil or dust that contains lead ~~derived from lead-based paint.~~at a concentration that constitutes a lead poisoning hazard.

(7) "Lead poisoning hazard" means any of the ~~presence of readily accessible or mouthable lead-bearing substances, including lead-based paint, measuring 1.0 milligram per square centimeter or greater by X-ray fluorescence or five tenths of one percent (0.5%) or greater by chemical analysis; or 15 parts per billion or greater in drinking water; or 100 micrograms per square foot or greater for dust on floors; or 500 micrograms per square foot or greater for dust on windowsills; or 800 micrograms per square foot or greater for dust in window troughs, or soil lead concentrations in an amount greater than or equal to 400 parts per million that is determined by the Department to present a hazard in light of (i) the condition and use of the land and (ii) other relevant factors.~~following:

a. Any lead-based paint or other substance that contains lead in an amount equal to or greater than 1.0 milligrams lead per square centimeter as determined by X-ray fluorescence or five-tenths of a percent (0.5%) lead by weight as determined by chemical analysis: (i) on any readily accessible or chewable surface on which there is evidence of teeth marks or mouthing; or (ii) on any other deteriorated or otherwise damaged interior or exterior surface.

b. Any substance that contains lead intended for use by children less than six years of age in an amount equal to or greater than 0.06 percent (0.06%) lead by weight as determined by chemical analysis.

c. Any concentration of lead dust that is equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills, vinyl miniblinds, bathtubs, kitchen sinks, or lavatories.

d. Any lead-based paint or other substance that contains lead on a friction or impact surface that is subject to abrasion, rubbing, binding, or damage by repeated contact and where the lead dust concentrations on the nearest horizontal surface underneath the friction or impact surface are equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills.

e. Any concentration of lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of a residential housing unit or child-occupied facility equal to or greater than 400 parts per million. Any concentration of lead in bare soil in other locations of the yard equal to or greater than 1,200 parts per million.

f. Any ceramic ware generating equal to or greater than three micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms of lead per milliliter for cups, mugs, and pitchers as determined by Method 973.32 of the Association of Official Analytical Chemists.

g. Any concentration of lead in drinking water equal to or greater than 15 parts per billion.

(8) "Lead-safe housing" is housing that was built since 1978 or has been tested by a person that has been certified to perform risk assessments and found to have no lead-based paint hazard within the meaning of the Residential Lead-Based Paint Reduction Act of 1992, 42 U.S.C. § 4851b(15).

(9) "Maintenance standard" means the following:

a. Using safe work practices, repairing and repainting areas of deteriorated paint inside a residential housing unit and for single-family and duplex residential dwelling built ~~prior to~~before 1950, repairing and repainting areas of deteriorated paint on interior and exterior surfaces;

b. Cleaning the interior of the unit to remove dust that constitutes a lead poisoning hazard;

c. Adjusting doors and windows to minimize friction or impact on surfaces;

d. Subject to the occupant's approval, appropriately cleaning any carpets;

e. Taking such steps as are necessary to ensure that all interior surfaces on which dust might collect are readily cleanable; and

f. Providing the occupant or occupants all information required to be provided under the Residential Lead-Based Paint Hazard Reduction Act of 1992, and amendments thereto.

(10) "Managing agent" means any person who has charge, care, or control of a building or part thereof in which dwelling units or rooming units are leased.

(11) ~~"Mouthable lead-bearing substance" means any substance on surfaces or fixtures five feet or less from the floor or ground that form a protruding corner or similar edge, or protrude one-half inch or more from a flat wall surface, or are freestanding, containing lead-contaminated dust at a level that constitutes a lead poisoning hazard. Mouthable surfaces or fixtures include toys, vinyl miniblinds,~~

~~doors, door jambs, stairs, stair rails, windows, windowsills, and baseboards.~~

(12) ~~"Persistent elevated blood lead level" means a blood lead concentration of 15-19 micrograms per deciliter determined by the lowest of three consecutive blood tests. The first two blood tests shall be performed within a six-month period, and the third blood test shall be performed at least 12 weeks and not more than six months after the second blood test.~~

(13) "Readily accessible ~~lead-bearing~~ substance" means any substance ~~containing lead at a level that constitutes a lead poisoning hazard which~~that can be ingested or inhaled by a child ~~under 6~~less than six years of age. Readily accessible substances include deteriorated paint that is peeling, chipping, cracking, flaking, or blistering to the extent that the paint has separated from the substrate. Readily accessible substances also include soil, ~~water,~~water, toys, vinyl miniblinds, bathtubs, lavatories, doors, door jambs, stairs, stair rails, windows, interior windowsills, baseboards, and paint that is chalking.

(14) "Regularly visits" means the presence at a residential housing unit or child-occupied facility on at least two different days within any week, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours, and the combined annual visits last at least 60 hours.

(15) "Remediation" means the elimination or control of lead poisoning hazards by methods approved by the Department.

(16) "Residential housing unit" means a dwelling, dwelling unit, or other structure, all or part of which is designed or used for human habitation, including the common areas, the grounds, any outbuildings, or other structures appurtenant to the residential housing unit.

(17) "Supplemental address" means a residential housing unit or child-occupied facility where a child with ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning regularly visits or attends. Supplemental address also means a residential housing unit or child-occupied facility where a child resided, regularly visited, or attended within the six months immediately preceding the determination of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning."

SECTION 2. G.S. 130A-131.8 reads as rewritten:

"**§ 130A-131.8. Reports of blood levels in children.**

All laboratories doing business in this State shall report to the Department all blood lead ~~levels of one microgram per deciliter or greater~~test results for children less than ~~6~~ six years of age and for individuals whose ages are unknown at the time of testing. Reports shall be made within five working days after test completion on forms provided by the Department or on self-generated forms containing: the child's full name, date of birth, sex, race, address, and Medicaid number, if any; the name, address, and telephone

number of the requesting health care provider; the name, address, and telephone number of the testing laboratory; the laboratory results, the specimen type – venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed. ~~Such~~The reports may be made by electronic submissions."

SECTION 3. G.S. 130A-131.9 reads as rewritten:

"**§ 130A-131.9. Examination and testing.**

When the Department has a reasonable suspicion that a child less than ~~6~~ six years of age has ~~a persistent~~ an elevated blood lead level or a confirmed lead poisoning, the Department may require that child to be examined and tested within 30 days. The Department shall require from the owner, managing agent, or tenant of the residential housing unit or child-occupied facility information on each child who resides in, regularly visits, or attends, or, who has within the past six months, resided in, regularly visited, or attended the unit or facility. The information required shall include each child's name and date of birth, the names and addresses of each child's parents, legal guardian, or full-time custodian. The owner, managing agent, or tenant shall submit the required information within 10 days of receipt of the request from the Department."

SECTION 4. G.S. 130A-131.9A reads as rewritten:

"**§ 130A-131.9A. Investigation to identify lead poisoning hazards.**

(a) When the Department learns of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning, the Department shall conduct an investigation to identify the lead poisoning hazards to children. The Department shall investigate the residential housing unit ~~or child-occupied facility~~ where the child with ~~the persistent elevated blood lead level or the~~ confirmed lead poisoning ~~resides, regularly visits, or attends~~.resides. The Department shall also investigate the supplemental addresses of the child who has ~~a persistent elevated blood lead or a~~ confirmed lead poisoning.

(a1) When the Department learns of an elevated blood lead level, the Department shall, upon informed consent, investigate the residential housing unit where the child with the elevated blood level resides. When consent to investigate is denied, the child with the elevated blood lead level cannot be located, or the child's parent or guardian fails to respond, the Department shall document the denial of consent, inability to locate, or failure to respond.

(b) The Department shall also conduct an investigation when it reasonably suspects that a lead poisoning hazard to children exists in a residential housing unit or child-occupied facility occupied, regularly visited, or attended by a child less than ~~6~~ six years of age.

(c) In conducting an investigation, the Department may take samples of surface materials, or other materials suspected of containing lead, for analysis and testing. If samples are taken, chemical determination of the lead content of the samples shall be by atomic absorption spectroscopy or equivalent methods approved by the Department."

SECTION 5. G.S. 130A-131.9B reads as rewritten:

"**§ 130A-131.9B. Notification.**

Upon determination that a lead poisoning hazard exists, the Department shall give written notice of the lead poisoning hazard to the owner or managing agent of the residential housing unit or child-occupied facility and to all persons residing in,

attending, or regularly visiting the unit or facility. The written notice to the owner or managing agent shall include a list of possible methods of ~~abatement of the lead based paint hazards and of possible methods of remediation of any other lead poisoning hazard~~. remediation."

SECTION 6. G.S. 130A-131.9C reads as rewritten:

"**§ 130A-131.9C. ~~Abatement and remediation.~~Remediation.**

(a) Upon determination that a child less than ~~6~~ six years of age has a confirmed lead poisoning of 20 micrograms per deciliter or greater and that child resides ~~in, attends, or regularly visits,~~in a residential housing unit ~~or child-occupied facility~~ containing lead poisoning hazards, the Department shall require ~~abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards. The Department shall also require ~~the abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards identified at the supplemental addresses of a child less than ~~6~~ six years of age with a confirmed lead poisoning of 20 micrograms per deciliter or greater.

(b) When ~~abatement of lead-based paint hazards or~~ remediation of ~~other~~ lead poisoning hazards is required under subsection (a) of this section, the owner or managing agent shall submit a written remediation plan to the Department within 14 days of receipt of the lead poisoning hazard notification and shall obtain written approval of the plan ~~prior to~~before initiating ~~abatement of lead-based paint hazards or~~ remediation ~~of other lead poisoning hazards.~~activities. The remediation plan shall comply with subsections (g), (h), and (i) of this section.

(c) If the remediation plan submitted fails to meet the requirements of this section, the Department shall issue an order requiring submission of a modified plan. The order shall indicate the modifications ~~which~~ that shall be made to the remediation plan and the date ~~by which~~that the plan as modified shall be submitted to the Department.

(d) If the owner or managing agent does not submit a remediation plan within 14 days, the Department shall issue an order requiring submission of a remediation plan within five days of receipt of the order.

(e) The owner or managing agent shall notify the Department and the occupants of the dates of remediation activities at least three days ~~prior to the~~before commencement of the activities.

(f) ~~Abatement of lead-based paint hazards and remediation~~Remediation of ~~other~~ the lead poisoning hazards shall be completed within 60 days of the Department's approval of the remediation plan. If ~~these~~ the remediation activities are not completed within 60 ~~days as required,~~days, the Department shall issue an order requiring completion of the activities. An owner or managing agent may apply to the Department for an extension of the deadline. The Department may issue an order extending the deadline for 30 days upon proper written application by the owner or managing agent.

(g) ~~The~~ All of the following methods of ~~abatement~~ remediation of lead-based paint hazards are prohibited:

(1) Stripping paint on-site with methylene chloride-based ~~solutions;~~solutions.

(2) Torch or flame ~~burning;~~burning.
(3) Heating paint with a heat gun above 1,100 degrees ~~Fahrenheit;~~Fahrenheit.
(4) Covering with new paint or wallpaper unless all readily accessible lead-based paint has been ~~removed;~~removed.
(5) Uncontrolled abrasive ~~blasting; or~~ blasting, machine sanding, or grinding, except when used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at ninety-nine and seven-tenths percent (99.7%) or greater efficiency.
(6) Uncontrolled waterblasting.
(7) Dry scraping, unless used in conjunction with heat guns, or around electrical outlets, or when treating no more than two square feet on interior surfaces, or no more than 20 square feet on exterior surfaces.

(h) All lead-containing waste and residue shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules. Other substances containing lead that are intended for use by children less than six years of age and vinyl miniblinds that constitute a lead poisoning hazard shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules.

(i) All remediation plans shall require that the lead poisoning hazards be reduced to ~~below~~ the following levels:

(1) ~~Floor lead dust levels~~Less ~~are less~~ than ~~100~~ 40 micrograms per square ~~foot;~~foot for lead dust on floors.
(2) ~~Windowsill lead dust levels are less~~Less than ~~500~~ 250 micrograms per square ~~foot;~~foot for lead dust on interior windowsills, bathtubs, kitchen sinks, and lavatories.
(3) ~~Window trough lead dust levels are less~~Less than ~~800~~ 400 micrograms per square ~~foot;~~foot for lead dust on window troughs.
(4) ~~Soil lead levels are less~~Less than 400 parts per million ~~or such other level higher than 400 parts per million as determined by the Department to prevent a hazard in light of the condition and use of the land and in light of other relevant factors; and~~for lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of the residential housing unit or child-occupied facility. Lead in bare soil in other locations of the yard shall be reduced to less than 1,200 parts per million.
(5) ~~Drinking water lead levels less~~ Less than 15 parts per ~~billion.~~ billion for lead in drinking water.

(j) The Department shall verify by visual inspection that the approved remediation plan has been completed. The Department may also verify plan completion by residual lead dust monitoring and soil or drinking water lead level measurement.

(j1) Compliance with the maintenance standard satisfies the remediation requirements for confirmed lead poisoning cases identified on or after 1 October 1990 as long as all lead poisoning hazards identified on interior and exterior surfaces are

addressed by remediation. Except for owner-occupied residential housing units, continued compliance shall be verified by means of an annual monitoring inspection conducted by the Department. For owner-occupied residential housing units, continued compliance shall be verified (i) by means of an annual monitoring inspection, (ii) by documentation that no child less than six years of age has resided in or regularly visited the residential housing unit within the past year, or (iii) by documentation that no child less than six years of age residing in or regularly visiting the unit has an elevated blood lead level.

(k) Removal of children from the residential housing unit or child-occupied facility shall not constitute ~~abatement or~~ remediation if the property continues to be used for a residential housing unit or child-occupied ~~facility.~~facility. The remediation requirements imposed in subsection (a) of this section apply so long as the property continues to be used as a residential housing unit or child-occupied facility."

SECTION 7. G.S. 130A-131.9G reads as rewritten:

"**§ 130A-131.9G. Resident responsibilities.**

In any residential housing unit occupied by a child less than ~~6~~ six years ~~old~~ of age who has an elevated blood lead level of 10 micrograms per deciliter or greater, the Department shall advise, in writing, the owner or managing agent and the child's parents or legal guardian ~~as to~~of the importance of carrying out routine cleaning activities in the units they occupy, own, or manage. ~~Such~~ The cleaning activities shall ~~include:~~include all of the following:

(1) Wiping clean all windowsills with a damp cloth or sponge at least ~~weekly;~~weekly.

(2) Regularly washing all surfaces accessible to ~~children;~~children.

(3) In the case of a leased residential housing unit, identifying any deteriorated paint in the unit and notifying the owner or managing agent of ~~such~~ the conditions within 72 hours of ~~discovery; and~~discovery.

(4) Identifying and understanding potential lead poisoning hazards in the environment of each child ~~under the age of 6~~ less than six years of age in the unit (including toys, vinyl miniblinds, playground equipment, drinking water, soil, and painted surfaces), and taking steps to prevent children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

SECTION 8. This act becomes effective 1 July 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 519*
PROPOSED COMMITTEE SUBSTITUTE S519-PCS65246-RM-10

Short Title: Child Lead Poisoning Prevention Prgm Amends.-AB (Public)

Sponsors:

Referred to:

March 24, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-131.7 reads as rewritten:

"**§ 130A-131.7. Definitions.**

~~As used in this Part, unless the context requires otherwise, the term:~~The following definitions apply in this Part:

(1) "Abatement" means undertaking any of the following measures to eliminate a lead-based paint hazard:

a. Removing lead-based paint from a surface and repainting the surface.

b. Removing a component, such as a windowsill, painted with lead-based paint and replacing the component.

c. Enclosing a surface painted with lead-based paint with paneling, vinyl siding, or another approved material.

d. Encapsulating a surface painted with lead-based paint with a sealant.

e. Any other measure approved by the Commission.

(2) "Child-occupied facility" means a building, or portion of a building, constructed ~~prior to~~before 1978, regularly visited by a child who is less than ~~6~~ six years of age. Child-occupied facilities may include, but are not limited to, child care facilities, preschools, nurseries, kindergarten classrooms, schools, clinics, or treatment centers including the common areas, the grounds, any outbuildings, or other structures appurtenant to the facility.

(3) "Confirmed lead poisoning" means a blood lead concentration of 20 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(4) "Department" means the Department of Environment and Natural Resources or its authorized agent.

(5) "Elevated blood lead level" means a blood lead concentration of 10 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(6) "Lead-based paint hazard" means a condition that is likely to ~~cause adverse health effects as a~~ result ~~of~~ in exposure to lead-based paint or to soil or dust that contains lead ~~derived from lead-based paint.~~at a concentration that constitutes a lead poisoning hazard.

(7) "Lead poisoning hazard" means any of the ~~presence of readily accessible or mouthable lead-bearing substances, including lead-based paint, measuring 1.0 milligram per square centimeter or greater by X-ray fluorescence or five-tenths of one percent (0.5%) or greater by chemical analysis; or 15 parts per billion or greater in drinking water; or 100 micrograms per square foot or greater for dust on floors; or 500 micrograms per square foot or greater for dust on windowsills; or 800 micrograms per square foot or greater for dust in window troughs, or soil lead concentrations in an amount greater than or equal to 400 parts per million that is determined by the Department to present a hazard in light of (i) the condition and use of the land and (ii) other relevant factors.~~following:

a. Any lead-based paint or other substance that contains lead in an amount equal to or greater than 1.0 milligrams lead per square centimeter as determined by X-ray fluorescence or five-tenths of a percent (0.5%) lead by weight as determined by chemical analysis: (i) on any readily accessible substance or chewable surface on which there is evidence of teeth marks or mouthing; or (ii) on any other deteriorated or otherwise damaged interior or exterior surface.

b. Any substance that contains lead intended for use by children less than six years of age in an amount equal to or greater than 0.06 percent (0.06%) lead by weight as determined by chemical analysis.

c. Any concentration of lead dust that is equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills, vinyl miniblinds, bathtubs, kitchen sinks, or lavatories.

d. Any lead-based paint or other substance that contains lead on a friction or impact surface that is subject to abrasion, rubbing, binding, or damage by repeated contact and where the lead dust concentrations on the nearest horizontal surface underneath the

friction or impact surface are equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills.

e. Any concentration of lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of a residential housing unit or child-occupied facility equal to or greater than 400 parts per million. Any concentration of lead in bare soil in other locations of the yard equal to or greater than 1,200 parts per million.

f. Any ceramic ware generating equal to or greater than three micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms of lead per milliliter for cups, mugs, and pitchers as determined by Method 973.32 of the Association of Official Analytical Chemists.

g. Any concentration of lead in drinking water equal to or greater than 15 parts per billion.

(8) "Lead-safe housing" is housing that was built since 1978 or has been tested by a person that has been certified to perform risk assessments and found to have no lead-based paint hazard within the meaning of the Residential Lead-Based Paint Reduction Act of 1992, 42 U.S.C. § 4851b(15).

(9) "Maintenance standard" means the following:

a. Using safe work practices, repairing and repainting areas of deteriorated paint inside a residential housing unit and for single-family and duplex residential dwelling built ~~prior to~~before 1950, repairing and repainting areas of deteriorated paint on interior and exterior surfaces;

b. Cleaning the interior of the unit to remove dust that constitutes a lead poisoning hazard;

c. Adjusting doors and windows to minimize friction or impact on surfaces;

d. Subject to the occupant's approval, appropriately cleaning any carpets;

e. Taking such steps as are necessary to ensure that all interior surfaces on which dust might collect are readily cleanable; and

f. Providing the occupant or occupants all information required to be provided under the Residential Lead-Based Paint Hazard Reduction Act of 1992, and amendments thereto.

(10) "Managing agent" means any person who has charge, care, or control of a building or part thereof in which dwelling units or rooming units are leased.

(11) ~~"Mouthable lead-bearing substance" means any substance on surfaces or fixtures five feet or less from the floor or ground that form a protruding corner or similar edge, or protrude one-half inch or more~~

~~from a flat wall surface, or are freestanding, containing lead-contaminated dust at a level that constitutes a lead poisoning hazard. Mouthable surfaces or fixtures include toys, vinyl miniblinds, doors, door jambs, stairs, stair rails, windows, windowsills, and baseboards.~~

(12) ~~"Persistent elevated blood lead level" means a blood lead concentration of 15-19 micrograms per deciliter determined by the lowest of three consecutive blood tests. The first two blood tests shall be performed within a six-month period, and the third blood test shall be performed at least 12 weeks and not more than six months after the second blood test.~~

(13) "Readily accessible ~~lead-bearing~~ substance" means any substance ~~containing lead at a level that constitutes a lead poisoning hazard which~~that can be ingested or inhaled by a child ~~under 6~~less than six years of age. Readily accessible substances include deteriorated paint that is peeling, chipping, cracking, flaking, or blistering to the extent that the paint has separated from the substrate. Readily accessible substances also include soil, ~~water,~~water, toys, vinyl miniblinds, bathtubs, lavatories, doors, door jambs, stairs, stair rails, windows, interior windowsills, baseboards, and paint that is chalking.

(14) "Regularly visits" means the presence at a residential housing unit or child-occupied facility on at least two different days within any week, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours, and the combined annual visits last at least 60 hours.

(15) "Remediation" means the elimination or control of lead poisoning hazards by methods approved by the Department.

(16) "Residential housing unit" means a dwelling, dwelling unit, or other structure, all or part of which is designed or used for human habitation, including the common areas, the grounds, any outbuildings, or other structures appurtenant to the residential housing unit.

(17) "Supplemental address" means a residential housing unit or child-occupied facility where a child with ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning regularly visits or attends. Supplemental address also means a residential housing unit or child-occupied facility where a child resided, regularly visited, or attended within the six months immediately preceding the determination of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning."

SECTION 2. G.S. 130A-131.8 reads as rewritten:

"**§ 130A-131.8. Reports of blood levels in children.**

All laboratories doing business in this State shall report to the Department all blood lead ~~levels of one microgram per deciliter or greater~~test results for children less than ~~6~~ six years of age and for individuals whose ages are unknown at the time of testing.

Reports shall be made within five working days after test completion on forms provided by the Department or on self-generated forms containing: the child's full name, date of birth, sex, race, address, and Medicaid number, if any; the name, address, and telephone number of the requesting health care provider; the name, address, and telephone number of the testing laboratory; the laboratory results, the specimen type – venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed. ~~Such~~The reports may be made by electronic submissions."

SECTION 3. G.S. 130A-131.9 reads as rewritten:

"**§ 130A-131.9. Examination and testing.**

When the Department has a reasonable suspicion that a child less than ~~6~~six years of age has ~~a persistent~~ an elevated blood lead level or a confirmed lead poisoning, the Department may require that child to be examined and tested within 30 days. The Department shall require from the owner, managing agent, or tenant of the residential housing unit or child-occupied facility information on each child who resides in, regularly visits, or attends, or, who has within the past six months, resided in, regularly visited, or attended the unit or facility. The information required shall include each child's name and date of birth, the names and addresses of each child's parents, legal guardian, or full-time custodian. The owner, managing agent, or tenant shall submit the required information within 10 days of receipt of the request from the Department."

SECTION 4. G.S. 130A-131.9A reads as rewritten:

"**§ 130A-131.9A. Investigation to identify lead poisoning hazards.**

(a) When the Department learns of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning, the Department shall conduct an investigation to identify the lead poisoning hazards to children. The Department shall investigate the residential housing unit ~~or child-occupied facility~~ where the child with ~~the persistent elevated blood lead level or the~~ confirmed lead poisoning ~~resides, regularly visits, or attends.~~resides. The Department shall also investigate the supplemental addresses of the child who has ~~a persistent elevated blood lead or a~~ confirmed lead poisoning.

(a1) When the Department learns of an elevated blood lead level, the Department shall, upon informed consent, investigate the residential housing unit where the child with the elevated blood level resides. When consent to investigate is denied, the child with the elevated blood lead level cannot be located, or the child's parent or guardian fails to respond, the Department shall document the denial of consent, inability to locate, or failure to respond.

(b) The Department shall also conduct an investigation when it reasonably suspects that a lead poisoning hazard to children exists in a residential housing unit or child-occupied facility occupied, regularly visited, or attended by a child less than ~~6~~six years of age.

(c) In conducting an investigation, the Department may take samples of surface materials, or other materials suspected of containing lead, for analysis and testing. If samples are taken, chemical determination of the lead content of the samples shall be by atomic absorption spectroscopy or equivalent methods approved by the Department."

SECTION 5. G.S. 130A-131.9B reads as rewritten:

"**§ 130A-131.9B. Notification.**

Upon determination that a lead poisoning hazard exists, the Department shall give written notice of the lead poisoning hazard to the owner or managing agent of the residential housing unit or child-occupied facility and to all persons residing in, attending, or regularly visiting the unit or facility. The written notice to the owner or managing agent shall include a list of possible methods of ~~abatement of the lead-based paint hazards and of possible methods of remediation of any other lead poisoning hazard~~. remediation."

SECTION 6. G.S. 130A-131.9C reads as rewritten:

"**§ 130A-131.9C. ~~Abatement and remediation.~~Remediation.**

(a) Upon determination that a child less than ~~6~~ six years of age has a confirmed lead poisoning of 20 micrograms per deciliter or greater and that child resides ~~in, attends, or regularly visits,~~in a residential housing unit ~~or child-occupied facility~~ containing lead poisoning hazards, the Department shall require ~~abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards. The Department shall also require ~~the abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards identified at the supplemental addresses of a child less than ~~6~~ six years of age with a confirmed lead poisoning of 20 micrograms per deciliter or greater.

(b) When ~~abatement of lead-based paint hazards or~~ remediation of ~~other~~ lead poisoning hazards is required under subsection (a) of this section, the owner or managing agent shall submit a written remediation plan to the Department within 14 days of receipt of the lead poisoning hazard notification and shall obtain written approval of the plan ~~prior to~~before initiating ~~abatement of lead-based paint hazards or~~ remediation ~~of other lead poisoning hazards.~~activities. The remediation plan shall comply with subsections (g), (h), and (i) of this section.

(c) If the remediation plan submitted fails to meet the requirements of this section, the Department shall issue an order requiring submission of a modified plan. The order shall indicate the modifications ~~which~~ that shall be made to the remediation plan and the date ~~by which~~that the plan as modified shall be submitted to the Department.

(d) If the owner or managing agent does not submit a remediation plan within 14 days, the Department shall issue an order requiring submission of a remediation plan within five days of receipt of the order.

(e) The owner or managing agent shall notify the Department and the occupants of the dates of remediation activities at least three days ~~prior to the~~before commencement of the activities.

(f) ~~Abatement of lead-based paint hazards and remediation~~Remediation of ~~other~~ the lead poisoning hazards shall be completed within 60 days of the Department's approval of the remediation plan. If ~~these~~ the remediation activities are not completed within 60 ~~days as required,~~days, the Department shall issue an order requiring completion of the activities. An owner or managing agent may apply to the Department for an extension of the deadline. The Department may issue an order extending the deadline for 30 days upon proper written application by the owner or managing agent.

(g) ~~The~~ All of the following methods of ~~abatement~~ remediation of lead-based paint hazards are prohibited:

(1) Stripping paint on-site with methylene chloride-based ~~solutions;~~solutions.

(2) Torch or flame ~~burning;~~burning.

(3) Heating paint with a heat gun above 1,100 degrees ~~Fahrenheit;~~Fahrenheit.

(4) Covering with new paint or wallpaper unless all readily accessible lead-based paint has been ~~removed;~~removed.

(5) Uncontrolled abrasive ~~blasting; or~~ blasting, machine sanding, or grinding, except when used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at ninety-nine and seven-tenths percent (99.7%) or greater efficiency.

(6) Uncontrolled waterblasting.

(7) Dry scraping, unless used in conjunction with heat guns, or around electrical outlets, or when treating no more than two square feet on interior surfaces, or no more than 20 square feet on exterior surfaces.

(h) All lead-containing waste and residue shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules. Other substances containing lead that are intended for use by children less than six years of age and vinyl miniblinds that constitute a lead poisoning hazard shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules.

(i) All remediation plans shall require that the lead poisoning hazards be reduced to ~~below~~ the following levels:

(1) ~~Floor lead dust levels~~Less ~~are less~~ than ~~100~~ 40 micrograms per square ~~foot;~~foot for lead dust on floors.

(2) ~~Windowsill lead dust levels are less~~Less than ~~500~~ 250 micrograms per square ~~foot;~~foot for lead dust on interior windowsills, bathtubs, kitchen sinks, and lavatories.

(3) ~~Window trough lead dust levels are less~~Less than ~~800~~ 400 micrograms per square ~~foot;~~foot for lead dust on window troughs.

(4) ~~Soil lead levels are less~~Less than 400 parts per million ~~or such other level higher than 400 parts per million as determined by the Department to prevent a hazard in light of the condition and use of the land and in light of other relevant factors; and~~for lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of the residential housing unit or child-occupied facility. Lead in bare soil in other locations of the yard shall be reduced to less than 1,200 parts per million.

(5) ~~Drinking water lead levels less~~ Less than 15 parts per ~~billion.~~ billion for lead in drinking water.

(j) The Department shall verify by visual inspection that the approved remediation plan has been completed. The Department may also verify plan completion by residual lead dust monitoring and soil or drinking water lead level measurement.

(j1) Compliance with the maintenance standard satisfies the remediation requirements for confirmed lead poisoning cases identified on or after 1 October 1990 as long as all lead poisoning hazards identified on interior and exterior surfaces are addressed by remediation. Except for owner-occupied residential housing units, continued compliance shall be verified by means of an annual monitoring inspection conducted by the Department. For owner-occupied residential housing units, continued compliance shall be verified (i) by means of an annual monitoring inspection, (ii) by documentation that no child less than six years of age has resided in or regularly visited the residential housing unit within the past year, or (iii) by documentation that no child less than six years of age residing in or regularly visiting the unit has an elevated blood lead level.

(k) Removal of children from the residential housing unit or child-occupied facility shall not constitute ~~abatement or~~ remediation if the property continues to be used for a residential housing unit or child-occupied ~~facility.~~facility. The remediation requirements imposed in subsection (a) of this section apply so long as the property continues to be used as a residential housing unit or child-occupied facility."

SECTION 7. G.S. 130A-131.9G reads as rewritten:

"**§ 130A-131.9G. Resident responsibilities.**

In any residential housing unit occupied by a child less than ~~6~~ six years ~~old~~ of age who has an elevated blood lead level of 10 micrograms per deciliter or greater, the Department shall advise, in writing, the owner or managing agent and the child's parents or legal guardian ~~as to~~of the importance of carrying out routine cleaning activities in the units they occupy, own, or manage. ~~Such~~ The cleaning activities shall ~~include:~~include all of the following:

(1) Wiping clean all windowsills with a damp cloth or sponge at least ~~weekly;~~weekly.

(2) Regularly washing all surfaces accessible to ~~children;~~children.

(3) In the case of a leased residential housing unit, identifying any deteriorated paint in the unit and notifying the owner or managing agent of ~~such~~ the conditions within 72 hours of ~~discovery; and~~discovery.

(4) Identifying and understanding potential lead poisoning hazards in the environment of each child ~~under the age of 6~~ less than six years of age in the unit (including toys, vinyl miniblinds, playground equipment, drinking water, soil, and painted surfaces), and taking steps to prevent children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

SECTION 8. This act becomes effective 1 July 2003.

SENATE BILL 519:
Child Lead Poisoning Prevention Prgm. Amends

BILL ANALYSIS

Committee:	Senate Heatlh and Human Resources	**Introduced by:**	Sen. Purcell
		Summary by:	Linda Attarian Committee Counsel
Date:	April 2, 2003		
Version:	Introduced		

SUMMARY: ***Senate Bill 519 amends the law governing the Childhood Lead Poisoning Prevention Program within the Division of Environmental Health (Department) to revise the Program's environmental lead hazard and clean-up standards so that they are consistent with revised federal standards and guidelines; and to codify programmatic procedures currently in place with respect to investigations and remedial actions when a child is suspected or confirmed to have been exposed an environmental lead hazard. The bill is recommended by the Department as an agency bill and becomes effective July 1, 2003***

CURRENT LAW: The statutes governing the environmental lead hazard detection and remediation aspects of the North Carolina Childhood Lead Poisoning Prevention Program (NC CLPPP) are set forth in Part 4 of Article 5 of Chapter 130A.

Screening: Childhood lead poisoning has been a reportable condition under NC state law since 1990. Laboratories are required to report any test with a lead blood level of 1 microgram per deciliter (*u*g/dL) or greater to the Department. When the Department has a reasonable suspicion that a child less than 6 years old has a blood lead level of 15 *u*g/dL, the Department is authorized to require that the child be examined and tested for lead. Since 1994 the State Laboratory provides blood lead analysis at no charge for children who are uninsured.

Since 1998 NC CLPPP has implemented a statewide screening program targeting children between the ages of 12 and 24 months who are participating in the Medicaid, WIC, or Health Choice programs. Children under 6 years with lead poisoning (blood lead level of 20 *u*g/dL or higher) are provided with medical follow-up and health education as recommended by the National Centers for Disease Control (CDC) at the clinic where the child was screened.

Investigations: Under current law, when a child less than 6 years old has been screened and is found to have blood lead levels of 10 *u*g/dL or higher, the Department must advise the owner or manager of any residential housing unit occupied by the child about the importance of routine cleaning to prevent potential lead hazards.

When a child less than 6 years old has been identified with a blood lead levels of 15 *u*g/dL or higher, the Department is required to conduct an environmental investigation of residential housing unit or child care facility where the child resides, regularly visits, or attends. If the child has a blood lead level of 20 *u*g/dL or greater, the Department must also conduct an investigation of any supplemental addresses the child may have. During such an investigation, the family is interviewed and environmental samples are collected for laboratory analysis. Once the sources of lead exposure are identified, the owners of the residence or facility are notified. The costs associated with the investigation are reimbursable under Medicaid (up to $438 per child).

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES
Name of Committee

APRIL 2, 2003
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	ACS
	Capital Strategies
	ACS
	DMA
	DHHS
	DHHS
BRIAN SHANK	AZ
	EH&R
	HHS
	PhRMA
	GSK

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES
Name of Committee

APRIL 2, 2003
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Stevens	nursing
Polly Johnson	NC Board of Nursing
Howard Kramer	N.C. Board of Nursing
Sharon Pearce	NCANA
Kari Lucas	NCANA
Summer Wheat	Nursing
Mark Binson	Capitol Group
Ed Norman	DENR
R. Rogers	DENR
Kari Barsness	DENR
John McKay	DOU office

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES
Name of Committee

APRIL 2, 2003
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Virginia Hebert	Sen. Kinnaird
John Cyrus	N.C. State Grange
Abby Emanuelson	Nat'l MS Society
Hubert Tilson	NCHA
Amy Jo Horne	NCMS
Pamela Bird	LCC
ANN LORE	~~NCHA~~ OVHS
	NCAHP
Joyce Peters	JP Assoc.
David Knight	NC State

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
April 9, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Introduction of Lt. Governor Beverly Perdue**

III. **Bills to be Considered**

BILL NO.	SHORT TITLE	SPONSOR
• SB 657	Tanning Salons/Restrictions on Use	Sen. Forrester

IV. **Other Business**

V. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 9, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, April 9, 2003 in Room 544 of the Legislative Office Building. Eight members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator Purcell welcomed the committee members present and introduced the pages.

Senator Bingham introduced Lt. Gov. Beverly Perdue, the first female Lt. Gov. in the history of NC, to make a presentation on the Golden Leaf Tobacco Settlement Funds (attached) Lt. Gov. Perdue brought an up date from the Health Commission where they are on the investment of the tobacco settlement fund. For the ones who do not recall in 1999 when the tobacco settlement was being worked on by the Attorney General a group in the legislator came together with ideas of how to invest the moneys for the people of NC. For every dollar that came into this state from the tobacco settlement through legislation it was decided that fifty cents of the dollar would go to the Golden Leaf Fund, which is the fund that is charged with economic development activity in tobacco dependent communities. Twenty five cents goes to the Tobacco Farmers settlement fund which is for holders and growers and allotment owners The final twenty five cents would go to Health Care.

The Health Commission that was chartered in that piece of legislation was formally membered in May of 2001. They have been very aggressively active since then. Lt. Gov. Perdue is the acting chair of the commission and the Governor , the Speaker and the Pro Tem have appointees to the commission. There is a hand out (attached) from Jim Davis, who is the executive director. On the side of the cover letter it list the members of the commission. Money began to come to the commission in 2002. The focus was to be on the underserved and the vulnerable population, on research, education, and prevention. On building community based plans to prevent reduced and remedy the use of the tobacco effects on NC young people and to fund initiatives that help grow the community capacity for health care. The final piece was something a lot of us worked on being added. There's a strong component of accountabilities. So for every dollar that is invested in a grant thought out the state after the three year grant period and during the fruition of the grant period we are aggressively monitoring and evaluating. We intend to show that there are results for every dollar invested in the grantees where there might not be significant results we will not renew grants at the end of year one. The initiatives we have kicked off are in the hand out. The trifold is the description of the medical management and prescription drug program for older people, named Senior Care, and is working through DHHS. It was the first initiative of the health commission. $35,000,000.00 are set aside per year for people who are very poor in NC. It is a minuscule program, but it is a start for NC. It is targeted to three specific disease areas. The good news about the program is they are working very aggressively to get the Medicaid waver from the federal government. For every dollar we invest of the $35,000,000. of the tobacco trust money from NC we will bring down $3.00 more from the federal government so it will multiply by four the benefits of the program.

They also have put in place, The Medical Prescription Drug Assistant Program. It takes $5,000,000. of the commissions investment in drugs for older people and puts in place throughout the 100 counties, or through an 800 number, actual assistant prescription drug centers on the ground in your district. This means regardless of income based on a sliding scale you or your Mom or Dad could go into one of these centers and take their brown bag full of medication and dump it on a table and a pharmacist will be able to go through the drugs and actually figure out where the interaction might be. Why you might be dizzy if you are taking three different pills

prescribed by three different Doctors and work with the Doctors and the Medical Society in remedying that problem. The physicians have been incredible supportive because they want that for their patients.

The other two investments of the tobacco money, that we have made is on obesity reduction and prevention. Obesity is a serious issue in NC and the House is discussing a bill on physical education in K-8. The state board of education is addressing the same issue. We have a bill that is going to run through this committee that Sen. Purcell is involved in, putting nutritional guidelines into the school systems. We do not have that in North Carolina.

The final thing is yesterday we kicked off about a $20,000,000. initiative to combat teen smoking and cessation as well as prevention with community based grants across the state with a series of radio ads on hip hop rock and roll, kind of teen oriented, radio stations that are strong and focused. The good news for those of you from tobacco communities is the fact that we took the show on the road and did public hearings and did not hear one complaint from anybody that North Carolina was going to aggressively try to stop the stop smoking campaign. Not even the tobacco farmers in the heart of Eastern North Carolina would look at you and say I want my kid to start smoking. That is very important to the health of the state.

I am here today because I wanted to ask your help. I understand the money situation for the state as well as you do. The governor, in the budget that he sent over, asked that some of the money from the tobacco reserve fund be used to help get us through this third or fourth year of the budget crisis. The members of the health commission have no problem with that the reserve, in the wisdom of the general assembly, was the piece of the money set aside in a long term annuity. That is where his budget suggest that money be taken to help plug the hole in the budget. We are pleating with you as folks who have to face seniors and parents and kids not to let anybody invade the corpus, the projects we have up and running. Right now $135,000,000. obligated in tobacco funds, as you look at our spread sheet, we are going to receive $139,000,000. so any invasion of the principal would result in programs for people having to be cut. I would ask that you consider that very greatly.

Again I am just here to thank you, to thank the members of the General Assembly for in your wisdom creating this health commission and to understand and to know that you have people to help you with your constitutes. We will get you several copies as many as 50 per member of this tri-fold. Prescription Drugs for older people continue to be the thing we hear most about from the membership of the General Assembly from constituent inquires. Thank you for your time and your diligence and for your work on this committee.

Senator Purcell asked the Lt. Gov. about the recent law suit involving Philip Morris, what effect that will have on the money you are projected to receive. We can not give actual numbers but if Phillip Morris has to post the bond and goes into bankruptcy, which they have said they may have to, it would be an absolute severe lost. Not just to this state but to all of the states. Quite frankly I am a bit surprised the other 49 states have not picked up this passion. The Phillip Morris products seem to be one of the two largest contributors to the over all settlement. So long term if they divest themselves of the tobacco company and go off shore. As some of us have worried not just about them but of all the companies paying in you will see the whole thing go away. And if you recall back during the discussions when we set up all three commissions there were several of us who were afraid that would be the final outcome. That there would be a way in five six or seven years, to figure out how, not to have to pay into this settlement fund.

Senator Forrester was recognized to present, SB 657, ***Tanning Salons/Restrictions on Use***. Senator Forrester made a motion to adopt a committee substitute for purposes of discussions. Senator Queen seconded and the motion carried. He stated that only a couple of changes were made. The original bill said device and it was changed to tanning equipment. The various classifications that need parental consent were listed in a separate paragraph which is everyone under 18, and the section the radiation protection agency recommended on page 2 section 6 line 25-27. Skin cancer is the most commonly occouring cancer in the United States

with over one million people diagnosed with it every year. Ultra violate radiation from the sunlight as well as from artificial devices such as tanning beds is the main cause of this skin cancer and the most important environmental factor in development of skin cancer. Over one million people visit these tanning booths everyday. It is a known fact that tanning of any type is dangerous. The damage received from indoor lamps is just as dangerous as the outdoor sun exposure. Studies have shown that avoiding sunburns especially in childhood and adolescents may reduce the incidents of melanomas and premature aging of the skin. There are about 88,000 cases of melanoma in the United States every year. In the year of 2000 there were around 1200 cases of melanoma and 245 deaths from melanoma. That's about five deaths per week. That's a lot of people dying in our state from a particular illness.

Dr. Elizabeth P. Kanof past president of the North Medical Society and a Dermatologist was recognized to speak on the bill. There is no such thing as a safe tan. To say that the advantages of going to a tanning salon will give someone a base tan so that they will not burn as severely when they take a trip to the beach is fallacious. The feeling of well being when one has a tan is a culture thing, it is not based on sound medical science. Amy Jo Horne, representing the North Carolina Medical Society, spoke in favor of the bill stating protecting the children of the state is critical. .Marion Dearhake, ex officio member of NC Radiation Protection Commission, speaks today from personal experience of watching her father die from melanoma. Sun beds are known carcinogen.

Diane Jessup explained the first amendment from Senator Allran. It clarifies that owners and operators are responsible for insuring compliance with these new laws. The second amendment by Senator Allran, was for the permission from the parent to be notarized.

Senator Queen moved to roll the amendments into a new committee substitute and report the committee substitutes favorable unfavorable to original bill.

The meeting adjourned at 12:00 P.M.

Senator Stan Bingham, Co-Chair

Senator William Purcell, Co-Chair

Judy F. Chrisoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, April 10, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **657** Tanning Salons/Restrictions on Use.

Draft Number:	PCS 40002
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 657

Short Title:	Tanning Salons/Restrictions on Use.	(Public)
Sponsors:	Senator Forrester.	
Referred to:	Health & Human Resources.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT.

Whereas, on an average day in the United States, more than one million people visit indoor tanning salons for the purpose of tanning the skin; and

Whereas, studies have found that indoor tanning may be just as harmful to the skin as outdoor sun exposure; and

Whereas, most indoor tanning salon bulbs provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and cause various types of damage to the skin that may lead to skin cancer; and

Whereas, past studies have suggested that tanning beds contribute to the incidence of melanoma, and a recent study in the Journal of the National Cancer Institute indicates that the use of tanning devices may also contribute to the incidence of nonmelanoma skin cancers; and

Whereas, dermatologists across the country are alarmed with the number of teenagers and young adults who continue to patronize tanning salons regardless of studies reporting the link between sun exposure and a wide array of skin cancers; and

Whereas, the Centers for Disease Control and Prevention reports an estimated 700 emergency department visits per year related to tanning salon exposure; Now, therefore,

Be it resolved by the Senate, the House of Representatives concurring:

SECTION 1. Chapter 104E of the General Statutes is amended by adding the following new section to read:

"**§ 104E-109.1. Restrictions on use and operation of tanning equipment.**

(a) The operator of a tanning facility subject to regulations adopted pursuant to this Chapter shall comply with the following:

(1) Provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to ultraviolet radiation. The consumer shall be required to sign the warning

statement acknowledging receipt of the warning before initial use of the tanning equipment.

(2) The operator shall not allow a person younger than the age of 13 years to use a tanning device unless:

a. The facility receives written permission from the person's physician allowing the person to use the tanning device, and

b. The person's parent or legal guardian remains at the tanning facility while the person uses the tanning device.

(3) Before any person 16 or 17 years of age uses a tanning facility device for the first time, the person must give the tanning facility operator a written informed consent statement signed and dated by the person's parent or legal guardian stating that the parent or legal guardian has read and understands the warnings given by the tanning facility, consents to the minor's use of the tanning device, and agrees that the minor will use protective eyewear. In addition, a person 13, 14, or 15 years of age must be accompanied by a parent or legal guardian who must remain at the tanning facility while the person uses the tanning device.

(4) A tanning facility operator may not claim or distribute promotional materials that claim that using a tanning device is safe or free from risk or that using a tanning device will result in medical or health benefits.

(b) The Commission may adopt and the Department shall enforce rules to implement this section. The requirements of this section are in addition to other regulatory requirements adopted pursuant to this Chapter that are applicable to tanning facilities and do not conflict with this section.

(c) As used in this section, unless the context requires otherwise, the term:

(1) 'Consumer' means any individual who is provided access to a tanning facility that is subject to registration and regulation under this Chapter.

(2) 'Tanning facility' means any location, place, area, structure, or business that provides consumers access to tanning equipment.

(3) 'Tanning equipment' means ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the irradiation of any part of the living human body with ultraviolet radiation."

SECTION 2. This act becomes effective October 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 657
PROPOSED COMMITTEE SUBSTITUTE S657-PCS40002-SW-10

Short Title: Tanning Salons/Restrictions on Use. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT.

Whereas, on an average day in the United States, more than one million people visit indoor tanning salons for the purpose of tanning the skin; and

Whereas, studies have found that indoor tanning may be just as harmful to the skin as outdoor sun exposure; and

Whereas, most indoor tanning salon bulbs provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and cause various types of damage to the skin that may lead to skin cancer; and

Whereas, past studies have suggested that tanning beds contribute to the incidence of melanoma, and a recent study in the Journal of the National Cancer Institute indicates that the use of tanning devices may also contribute to the incidence of nonmelanoma skin cancers; and

Whereas, dermatologists across the country are alarmed with the number of teenagers and young adults who continue to patronize tanning salons regardless of studies reporting the link between sun exposure and a wide array of skin cancers; and

Whereas, the Centers for Disease Control and Prevention reports an estimated 700 emergency department visits per year related to tanning salon exposure; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 104E of the General Statutes is amended by adding the following new section to read:

"**§ 104E-9.1. Restrictions on use and operation of tanning equipment.**

(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person younger than the age of 18 years to use tanning equipment unless the person gives the operator a written informed consent statement signed and dated by the person's parent or legal guardian and sworn before a notary public stating that the parent or legal guardian has read and understands the warnings given by the tanning facility, consents to the minor's use of the tanning equipment, and agrees that the minor shall use protective eyewear.

(3) The operator shall not allow a person younger than the age of 13 years to use tanning equipment unless:

a. The tanning facility receives written permission from the person's physician allowing the person to use the tanning equipment, and

b. The person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(4) The operator shall not allow a person 13, 14, or 15 years of age to use tanning equipment unless the person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(5) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits.

(6) The operator shall not allow a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the tanning equipment.

(b) The Commission may adopt and the Department shall enforce rules to implement this section. The requirements of this section are in addition to other rules adopted pursuant to this Chapter that are applicable to tanning facilities and do not conflict with this section.

(c) As used in this section, unless the context requires otherwise, the term:

(1) 'Consumer' means any individual who is provided access to a tanning facility that is subject to registration and regulation under this Chapter.

(2) 'Tanning facility' means any location, place, area, structure, or business that provides consumers access to tanning equipment. For the purpose of this definition, tanning equipment registered to different persons at the same location and tanning equipment registered to the same person, but at separate locations, shall constitute separate tanning facilities.

(3) 'Tanning equipment' means ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the irradiation of any part of the living human body with ultraviolet radiation."

SECTION 2. This act becomes effective October 1, 2003.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 4/9/03

S. B. No. 657 Amendment No. 1
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

Rep.)
Sen.) _____

moves to amend the bill on page 1, lines 25-26

( ) WHICH CHANGES THE TITLE

by rewriting the lines to read:

"(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following: "; and

on page 2, line 22, by rewriting the line to read:

"(5) Neither an operator nor an owner shall claim or distribute promotional materials that ".

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

moves to amend the bill on page 2, line 38

( ) WHICH CHANGES THE TITLE

by ~~adding at the end of the sentence~~ ~~"notarized"~~ inserting after "guardian" the phrase "and sworn before a notary public".

ADOPTED _____ FAILED _____ TABLED _____

SIGNED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 657
PROPOSED COMMITTEE SUBSTITUTE S657-CSSW-10 [v.4]

4/8/2003 4:00:37 PM

Short Title: Tanning Salons/Restrictions on Use. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT IMPOSING RESTRICTIONS ON THE USE AND OPERATION OF TANNING FACILITIES AND EQUIPMENT.

Whereas, on an average day in the United States, more than one million people visit indoor tanning salons for the purpose of tanning the skin; and

Whereas, studies have found that indoor tanning may be just as harmful to the skin as outdoor sun exposure; and

Whereas, most indoor tanning salon bulbs provide a significant amount of UVA and UVB radiation, both types of which are found in the outdoor sun and cause various types of damage to the skin that may lead to skin cancer; and

Whereas, past studies have suggested that tanning beds contribute to the incidence of melanoma, and a recent study in the Journal of the National Cancer Institute indicates that the use of tanning devices may also contribute to the incidence of nonmelanoma skin cancers; and

Whereas, dermatologists across the country are alarmed with the number of teenagers and young adults who continue to patronize tanning salons regardless of studies reporting the link between sun exposure and a wide array of skin cancers; and

Whereas, the Centers for Disease Control and Prevention reports an estimated 700 emergency department visits per year related to tanning salon exposure; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 104E of the General Statutes is amended by adding the following new section to read:

"**§ 104E-9.1. Restrictions on use and operation of tanning equipment.**

(a) The operator of a tanning facility subject to rules adopted pursuant to this Chapter shall comply with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to

ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person younger than the age of 18 years to use tanning equipment unless the person gives the operator a written informed consent statement signed and dated by the person's parent or legal guardian stating that the parent or legal guardian has read and understands the warnings given by the tanning facility, consents to the minor's use of the tanning equipment, and agrees that the minor shall use protective eyewear.

(3) The operator shall not allow a person younger than the age of 13 years to use tanning equipment unless:

a. The tanning facility receives written permission from the person's physician allowing the person to use the tanning equipment, and

b. The person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(4) The operator shall not allow a person 13, 14, or 15 years of age to use tanning equipment unless the person's parent or legal guardian remains at the tanning facility while the person uses the tanning equipment.

(5) An operator shall not claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits.

(6) The operator shall not allow a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the tanning equipment.

(b) The Commission may adopt and the Department shall enforce rules to implement this section. The requirements of this section are in addition to other rules adopted pursuant to this Chapter that are applicable to tanning facilities and do not conflict with this section.

(c) As used in this section, unless the context requires otherwise, the term:

(1) 'Consumer' means any individual who is provided access to a tanning facility that is subject to registration and regulation under this Chapter.

(2) 'Tanning facility' means any location, place, area, structure, or business that provides consumers access to tanning equipment. For the purpose of this definition, tanning equipment registered to different persons at the same location and tanning equipment registered to the same person, but at separate locations, shall constitute separate tanning facilities.

(3) 'Tanning equipment' means ultraviolet or other lamps and equipment containing such lamps intended to induce skin tanning through the irradiation of any part of the living human body with ultraviolet radiation."

SECTION 2. This act becomes effective October 1, 2003.

SENATE BILL 657:
Tanning Salons/Restrictions on Use

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Sen. Forrester
		Summary by:	Dianna Jessup Committee Counsel
Date:	April 9, 2003		
Version:	PCS S657-CSSW-10		

SUMMARY: ***Senate Bill 657 would impose restrictions on the use of tanning equipment by minors, prohibit operators in tanning facilities from claiming that tanning equipment is safe, and prohibit operators from allowing persons to use tanning equipment longer than the recommended exposure time by the manufacturer of the equipment. Violations could result in administrative penalties. The act would become effective October 1, 2003.***

The PCS clarifies the language as it relates to the use of tanning equipment by minors and adds a provision that prohibits an operator from allowing a person to use tanning equipment longer than the recommended exposure time provided by the manufacturer.

CURRENT LAW: The Radiation Protection Commission is a statutorily-created commission within the Department of Environment and Natural Resources (Department) charged with adopting rules providing for a program to regulate and inspect sources of nonionizing radiation, which includes tanning equipment. Current rules require tanning facilities to register with the Department and renew their registration annually and also address the posting of warning signs, equipment requirements, the wearing of protective eyewear, what records must be maintained, registration of persons who service tanning equipment, and fees for registration. Operators of tanning equipment must be trained and certified.

Specific to this bill, the rules require operators to provide consumers the opportunity to read a copy of the warning concerning exposure to radiation and to request that the consumer sign the statement, prohibit registrants from allowing a person under age 18 to use tanning equipment unless the person provides a consent form signed by that person's parent, and require remote timers on tanning equipment with a maximum timer interval that does not exceed the manufacturer's maximum recommended exposure time.

The Department may impose an administrative penalty on any person who fails to comply with the rules. Each day of a continuing violation constitutes a separate violation. An administrative penalty may not exceed $10,000 per day. Penalties may be contested.

BILL ANALYSIS: In addition to the rules prescribed for tanning facilities, operators must comply with the following:

- Provide a warning statement to the consumer and obtain the consumer's signature acknowledging receipt of the statement before allowing the consumer to use the tanning equipment for the first time. Current rules require operators to provide the consumer the "opportunity" to read the warning and to "request" the consumer to sign the statement.
- Operators could not allow persons to use tanning equipment longer than the recommended exposure time provided by the manufacturer of the tanning equipment as shown on the label of the equipment. Current rules require timers with a maximum timer interval that does not exceed the manufacturer's maximum recommended exposure time.

- Operators would be prohibited from claiming or distributing promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits. Current rules do not address this issue.
- Operators could only allow persons under 18 to use tanning equipment subject to the following restrictions:
    - *16 and 17 year olds* would be required to provide a signed consent from the person's parent or guardian.
    - *13, 14, and 15 year olds* would be required to provide the signed parental consent form and a parent must be present at the tanning facility in order for the person to use the tanning equipment.
    - *Persons under 13* would be required to provide the signed parental consent form, written permission from the person's physician to use the tanning equipment, and a parent must be present at the tanning facility in order for the person to use the tanning equipment.

The Commission would be permitted to adopt rules to implement the requirements described above. The Department, as in other matters relating to tanning equipment, would enforce the rules.

Finally, the bill defines the terms "consumer", "tanning facility", and "tanning equipment". These definitions are consistent with the definitions for these terms currently in the rules.

S657-SMSW-001

State of North Carolina
Health & Wellness Trust Fund Commission

Governor
Michael F. Easley

Lieutenant Governor
Beverly E. Perdue,
Chair

Hon. MaryAnn E. Black,
County Commissioner,
Durham County, Durham

Carole W. Bruce,
Partner,
Smith Moore LLP

Donald E. Ensley, PhD,
Associate Professor and Chair,
Dept. of Community Health,
East Carolina University,
Greenville

Dan Gottovi, MD,
Physician,
Wilmington Health Associates,
Wilmington

Jeffrey L. Houpt, MD,
Dean, School of Medicine,
Vice Chancellor for Medical Affairs,
CEO,
UNC Health Care System,
Chapel Hill

Olson Huff, MD,
Asheville

Anita L. Jackson, MD, MPH, FACS
President,
Greater Carolina Ear, Nose,
and Thoat, PA
Lumberton

Elizabeth H. Locke, PhD,
President,
The Duke Endowment,
Charlotte

Ann Franklin Maxwell,
Charlotte

Leigh Harvey McNairy,
Officer/Director
Harvey Enterprises and Associates,
Kinston

Edwin W. Monroe, MD,
Emeritus Executive Dean,
Brody School of Medicine,
Greenville

Robert S. (Bob) Parker,
Vice President,
Home and Community Health,
North Carolina Baptist Hospital,
Tobacco Related Health
Care Issues,
Winston-Salem

Ralph Snyderman, MD,
Chancellor for Health Affairs,
Duke University,
Durham

Rebecca H. Wartman, OD,
Optometrist,
Doctors Vision Center,
Asheville

Paul M. Wiles,
President and CEO,
Novant Health,
Winston-Salem

Charles Willson, MD,
Clinical Professor and Asst. Dean,
Physicians Affairs,
School of Medicine,
East Carolina University,
Greenville

Robert E. Zaytoun,
Partner,
Zaytoun & Miller, PLLC,
Raleigh

Date: February 10, 2003

To: NC General Assembly Members

From: Lt. Governor Beverly Perdue

Subject: Health and Wellness Trust Fund Commission Progress Report

The vision expressed by the General Assembly in creating a Commission to improve the health and wellness of all North Carolinians is being realized today. The Health and Wellness Trust Fund Commission is using its 25% share of the state's tobacco settlement funds to vigorously implement a variety of initiatives addressing the most critical health challenges facing our population. Enclosed you will find a summary of achievements since our establishment in May 2001.

In addition to creating a prescription drug program for seniors, the Commission has awarded 63 grants to organizations statewide to reduce teen tobacco use, to assist low-income citizens in obtaining prescription drugs and to counsel seniors about safe use of their medicines. In awarding these grants, the Commission was mindful of its obligation to build capacity in underserved communities and to ensure geographic dispersion of resources. Enclosed is a map showing grant service areas established thus far. As its next priority, the Commission will be tackling the alarming epidemic of obesity among our youth.

The state's budget crisis has already claimed $70 million from the Health and Wellness Trust Fund. Any additional erosion of the funds will necessitate cancellation of grants and services already promised to our state's neediest citizens. Survival of these programs will not only result in direct services to your constituents in the near term, but will yield measurable outcomes that can be used to shape effective health care policy in the future.

If you have questions, or require additional information, please feel free to contact the Commission's Executive Director, Jim Davis.

Jim Davis, Executive Director
Post Office Box 24976, Raleigh, NC 27611 • 116 West Jones Street, Raleigh, NC 27603
Phone (919) 733-4011 • Fax (919) 733-1240

OVERVIEW OF HWTFC FUNDED INITIATIVES

Senior Care- the prescription drug plan for NC Seniors

The Commission allocated funding of $32 million dollars per year for three years for a prescription drug plan for North Carolina seniors. *Senior Care* covers those aged 65 and over, whose annual incomes total no more than 200% of the Federal Poverty Guidelines ($17,180 for an individual and $23,220 per couple) and who are without third party insurance (public or private). Approximately 100,000 seniors will be covered.

The program is disease-specific, covering three diseases that affect 70% of NC's seniors: cardiovascular disease, diabetes mellitus and chronic obstructive pulmonary disease (COPD). Using the *Senior Care* card, participants can purchase up to $1,000 worth of covered drugs per year, with the plan covering 60% of that expense, and the participant paying the other 40%.

The Commission designated NCDHHS to hire a commercial vendor to manage the program. Through competitive bidding, ACS was selected to serve as the Pharmacy Benefit Manager. Seniors began using their cards to access their drug benefit on November 1, 2002. Enrollment outreach is being conducted statewide through health departments, senior centers, pharmacies and physicians.

Senior Care's annual budget could expand from $32 million to $90 million if the federal government approves North Carolina's Medicaid waiver application that was recently submitted. The Commission's funds represent the state match required to access federal funds upon approval of this waiver request. With increased funding *Senior Care* would be expanded to cover prescriptions for all disease states. Also, the program would pay for the first $1,000 of prescription drug expenditure, at a nominal co-pay of $5 for generic drugs and $15 for brand name drugs, per 30-day prescription.

At the end of each year of the program, the General Assembly will receive the results of an outcomes analysis being conducted jointly by the UNC Schools of Public Health and Pharmacy and North Carolina A&T State University School of Nursing.

Prescription Assistance Centers.

On October 23, 2002, the Commission awarded a total of $8.7 million over three years to fund 24 community-based programs (list enclosed) to assist North Carolina seniors and low-income individuals of all ages in acquiring free, low-cost or discounted medications. In addition, any senior will be able to receive counseling on the safe and wise use of prescription drugs. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and emphasized the creation of new health care capacity within local communities.

Grant recipients will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for *Senior Care* will receive such counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay. The UNC School of Pharmacy will provide medication counseling through a toll-free hotline for those seniors who reside in counties without a local Prescription Assistance Center present.

National studies have shown that nearly 17% of hospitalizations involving seniors are the result of adverse reactions to medications, costing tens of billions of dollars to the health care system.

The grant will also cover the cost of both salary and training for Prescription Access Coordinators who will operate specially designed software provided by DHHS. These Coordinators will use the software to help clients locate and apply for the lowest-cost prescription drugs available, including card programs offered by pharmaceutical companies. The grantees may also provide educational services to help low-income seniors manage chronic diseases.

Approval of the Medicaid waiver discussed above would expand the annual budget for these Prescription Assistance Centers from $3 million to $12 million.

Teen Tobacco Use Prevention and Cessation Initiative

The Commission allocated $18.6 million to this initiative for a three-year pilot program, and completed grant awards in December of 2002. The plan conforms to recommendations from the CDC by providing NC communities with training and resources necessary to design and implement local prevention and cessation programs. Further, it places emphasis on reducing youth tobacco use through public education using both paid and earned media, school-based interventions, teen cessation programs and enforcement of the state law restricting tobacco sales to minors (G.S. 14-313).

Tobacco use rates among NC high school and middle school students are above the national rate. An alarming 38.3% of NC high school students and 18.4% of middle school students are current users of tobacco. This initiative is the largest investment the State has made to reduce teen tobacco use. It is estimated that North Carolina's health care costs attributable to tobacco use exceed $1 billion annually (*NC VISION 2010, 2001*). This upfront investment to reduce tobacco use among teens could greatly reduce these costs.

The program is organized into these specific components:

$7,003,377 - for 27 local community/school prevention programs, plus training and technical support services (list enclosed).

$2,425,000 - for 4 statewide organizations to address the disproportionate health impacts of tobacco use among African American, American Indian, and Latino youth; plus training and technical support (list enclosed).

$3,600,000 - for media messages designed to prevent and reduce youth tobacco use.

$1,500,000 - to reduce tobacco sales to minors through statewide enforcement of North Carolina's law prohibiting the sale and distribution of tobacco products to youth (G.S. 14-313).

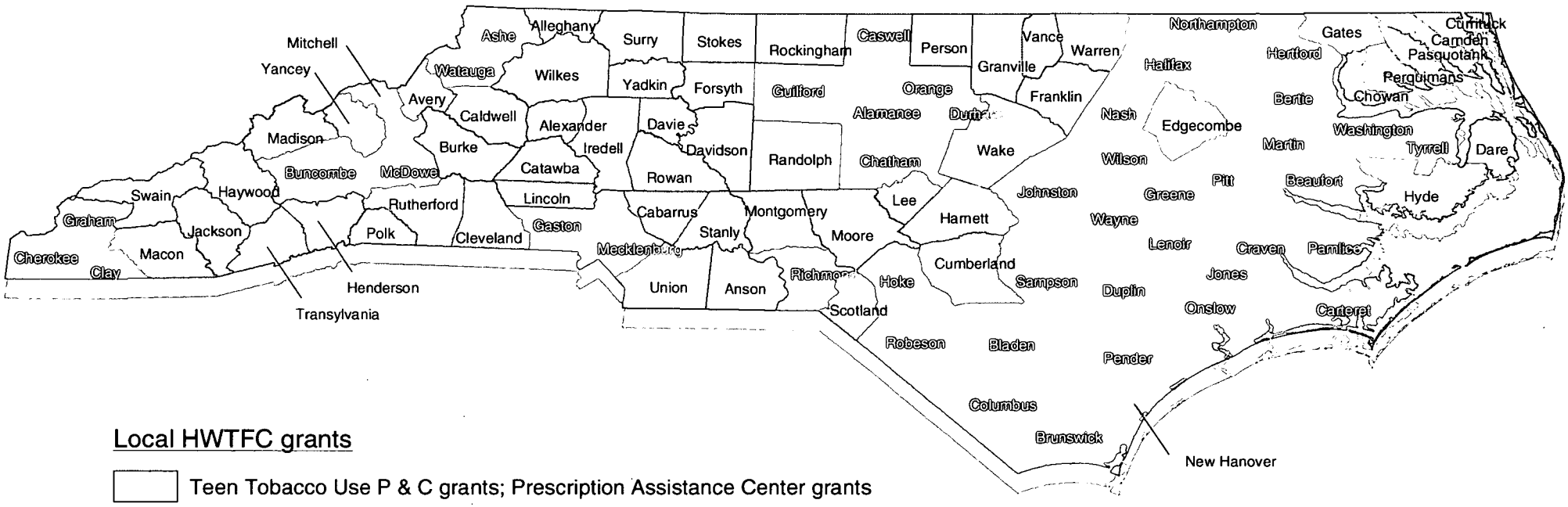
$2,365,000 - for a toll-free Quit Line and website in years 2 and 3 of the initiative that will help callers quit, provide information on treatment options, and offer follow-up support.

$600,000 - for training, technical assistance and implementation of the school-based teen cessation program Not-on-Tobacco (N-O-T), which is provided by the American Lung Association.

$300,000 - to expand smoking cessation intervention in the routine health care visits of pregnant teenage women.

$800,000 - for an ongoing outcome analysis that will assure that the funded programs are having their intended impact of reducing teen tobacco use.

HWTFC Grants Awarded in 2002



Local HWTFC grants

- Teen Tobacco Use P & C grants; Prescription Assistance Center grants
- Prescription Assistance Center grants
- Teen Tobacco Use Prevention and Cessation grants
- Access to Medication Management Hotline; statewide Teen Tobacco Use P & C programs

Map created at the UNC School of Public Health by Lisa E. Fastnaught, MPH, and Kurt M. Ribisl, Ph.D. on January 29, 2002

HWTFC PRESCRIPTION ASSISTANCE CENTER GRANT AWARDS

Name of Organization	Counties Served	3-year Funding
Alamance Regional Medical Center	Alamance, Caswell	$ 287,500
Bladen HealthWatch	Bladen	$ 280,768
Caldwell Senior Center	Caldwell	$ 176,500
Cape Fear Council of Government AAA	New Hanover, Brunswick, Columbus, Pender	$ 398,000
Cherokee County Health Department	Cherokee, Clay, Graham	$ 444,696
Cumberland County Hospital System, Inc.	Cumberland	$ 450,000
Eastern Carolina Council AAA	Carteret, Duplin, Greene, Lenoir, Craven, Onslow, Pamlico, Jones, Wayne	$ 802,000
Gaston Family Health Center	Gaston	$ 232,750
Guilford County Health Department	Guilford	$ 448,957
Isothermal Planning AAA	Rutherford, Cleveland, Polk, McDowell	$ 514,521
Lumber River Council of Governments	Robeson, Bladen, Hoke, Richmond and Scotland	$ 416,000
Martin-Tyrrell-Washington District Health Department	Washington, Martin, Tyrrell	$ 409,000
MedAssist	Mecklenburg	$ 268,000
Mid-East Commission AAA	Beaufort, Bertie, Hertford and Pitt	$ 456,960
Mission St. Joseph	Buncombe, Madison, Yancey, Mitchell	$ 396,000
NC Commission of Indian Affairs	Bladen, Columbus, Cumberland, Harnett, Hoke, Sampson	$ 243,302
Piedmont Triad Council of Government AAA	Montgomery, Randolph	$ 145,000
Resources for Seniors, Inc.	Wake, Franklin, Johnston, Lee	$ 466,000
Rural Health Group, Inc.	Halifax, Northampton	$ 412,200
Senior PHARMAssist, Inc.	Durham	$ 208,000
The Hunger Coalition	Ashe, Avery, Watauga	$ 336,000
UNC School of Pharmacy (includes hotline)	Orange, Chatham	$ 256,846
Wilson Community Health Center	Wilson, Nash	$ 389,000
Winston-Salem Urban League*	Forsyth	$ 262,000
Total:		**$ 8,700,000**

2/4/03

HWTFC COMMUNITY/SCHOOL GRANT AWARDS
TEEN TOBACCO USE PREVENTION AND CESSATION INITIATIVE

Organization Name	Counties Served	3-Year Budget
Alamance-Caswell Area MH/DD/SA Authority	Alamance, Caswell	$ 200,000
Ashe County Schools/Ashe County Health Council	Ashe	$ 199,640
Buncombe County Schools/Safe and Drug Free Schools	Buncombe	$ 299,727
Cancer Services of Gaston County, Inc.	Gaston	$ 170,000
Catawba County Public Health Department	Catawba	$ 294,000
Chatham County Health Department	Chatham	$ 219,046
Chowan Regional Health Care Foundation	Bertie, Chowan, Perquimans, Tyrrell, Washington	$ 300,000
Durham County Health Department	Durham	$ 287,156
FirstHealth of the Carolinas	Richmond, Hoke	$ 280,613
Guilford County Project ASSIST	Guilford	$ 210,000
Halifax County Schools	Halifax	$ 292,080
Hertford-Gates Health Agency	Hertford, Gates	$ 198,307
Macon County Public Health Center	Macon	$ 135,366
McDowell County Schools	McDowell	$ 285,000
Mecklenburg County Health Department	Mecklenburg	$ 300,000
Mitchell County Schools	Mitchell	$ 278,750
N.C. Amateur Sports/State Games of North Carolina	Statewide	$ 285,000
Orange County Health Department	Orange	$ 232,848
Public Schools of Robeson County	Robeson	$ 283,500
Rowan County Health Department	Rowan	$ 228,000
SAVE of NC GASP	Statewide	$ 210,000

HWTFC COMMUNITY/SCHOOL GRANT AWARDS
TEEN TOBACCO USE PREVENTION AND CESSATION INITIATIVE

Organization Name	Counties Served	3-Year Budget
Surry County Health and Nutrition Center	Surry	$ 272,346
Toe River Health District	Yancey	Budget combined with Mitchell Co. Schools
Tri-County Community Health Partnership	Cherokee, Clay, Graham	$ 150,000
Union County Public Schools	Union	$ 283,998
Watauga County Schools	Watauga	$ 300,000
Wilmington Health Acces for Teens, Inc. (WHAT)	37 counties in Eastern NC: Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Sampson, Tyrell, Warren, Washington, Wayne, Wilson	$ 418,000
Total:		**$ 6,707,377**

* Indicates funds requested for counter-marketing, which have been earmarked for use by the grantee, and transferred into the centrally managed media fund.

HWTFC PRIORITY POPULATIONS GRANT AWARDS
TEEN TOBACCO USE PREVENTION AND CESSATION INITIATIVE

Organization Name	3-Year Budget
El Pueblo	$ 465,000
North Carolina Commission on Indian Affairs	$ 475,000
General Baptist State Convention	$ 475,000
Old North State Medical Society	$ 785,000
Total 3 Year Allocation	**$ 2,200,000**

2/4/03

Charlotte.com

Posted on Tue, Jan. 21, 2003 The Charlotte Observer

Program will help needy get medicine

Anyone within income rules is eligible for new statefunded program

MIKE STOBBE
Staff Writer

Peggy Jones placed vial after vial of prescription medicine on the table, 10 in all.

Jones, 65, couldn't afford all the pills. She was prescribed most of them last month, after doctors diagnosed a heart problem. The first month's supplies were free, but the pills were almost gone and would cost several hundred dollars to refill.

So she went to see Suzanne Walshe, who coordinates a free prescription assistance program that started in Charlotte last week.

The program is designed to help in two ways. It enrolls patients in pharmaceutical company programs that provide brand-name medications to needy patients for free or at a discount. It will also use volunteer doctors to check for drug interactions in patients who take an assortment of pills.

Walshe, 26, met with Jones Friday and quickly sorted through the yellow vials.

Walshe placed six to one side. "These are the ones we'll be able to help you with," she said.

The new program is housed at MedAssist of Mecklenburg, a charitable pharmacy at 5516 Central Ave., (704) 536-1790.

The program's funding comes from North Carolina's Health and Wellness Trust Fund Commission, which controls a portion of the state's $160 million annual share of the national tobacco litigation settlement.

The commission devoted $9 million over the next three years to establish 23 N.C. prescription assistance centers. The funding includes $268,000 for a center in the Charlotte area, awarded to MedAssist.

MedAssist normally serves only seniors, but the new prescription assistance program will serve anyone who meets income guidelines. A single person may not make more than $1,477 monthly, a couple no more than $1,900 monthly.

"Seniors especially need help paying for their prescription drugs, but this grant also will help people of any age who cannot afford their medication," said Lt. Gov. Beverly Perdue, who chairs the Health and Wellness Trust Fund Commission.

Perdue is to speak at MedAssist this morning to officially launch the program.

Jones, a retired photo retoucher, went to Carolinas Medical Center last month for breathing problems and was diagnosed with congestive heart failure.

She spent five days in the hospital, emerging Christmas Eve with prescriptions for five new medications, including two heart pills, a pain pill, a fluid pill and a blood pressure medicine.

She already was on five others, including medicines for diabetes and a thyroid problem.

Jones and her husband, Tom, a retired box factory maintenance worker, have Medicare coverage, but it doesn't cover prescriptions. Her monthly income is $1,288, with no spare cash for the new medicines.

"I could never afford it. I'd get it and instead of taking it every day, I'd probably skip a day. That's the only way I could afford to take this medicine," Jones said.

Jones said she wants to help MedAssist get the word out. "I think it's a good thing for people. I told a couple of my friends about it," she said.

The News Reporter
Whiteville, NC
D - 9,959 S - NO DATA
November 14, 2002
Carolina Clipping Service
Raleigh, NC 27603

tion. 153 -1423C -224-16

Prescription assistance grant for seniors awarded

The North Carolina Health and Wellness Trust Fund Commission has announced a grant of $398,000 to Cape Fear Council of Government AAA for prescription assistance service covering New Hanover, Brunswick, Columbus and Pender counties.

The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is a unique feature of our State's prescription drug benefit program, Senior Care. Seniors especially need help paying for their prescription drugs, but this grant also will help people of any age who cannot afford their medication. This innovative medical management program will help all our seniors get the proper treatment they need and deserve. It is a real win for North Carolina's communities and our elderly," said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fund Commission.

Funded organizations will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for Senior Care will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under this initiative, 23 new and existing community-based programs were selected by the Commission to receive a total of approximately $3 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to response to area health needs.

The Health and Wellness Trust Fund Commission was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The Commission is comprised of 18 individuals representing a wide background of health care experience throughout North Carolina.

The Wallace Enterprise
Wallace, NC
D – 7,020 S – NO DATA
November 14, 2002
Carolina Clipping Service
Raleigh, NC 27603

30-16-224 (142)

2

Local Organizations Awarded Prescription Assistance Grant for Seniors

The North Carolina Health and Wellness Trust Fund Commission today announced a grant of $802,000 to Eastern Carolina Council AAA for prescription assistance services covering Carteret, Duplin, Greene, Lenoir, Craven, Onslow, Pamlico, Jones and Wayne counties. The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is a unique feature of our State's prescription drug benefit program, Senior Care. Seniors especially need help paying for their prescription drugs, but this grant also will help people of any age who cannot afford their medication. This innovative medical management program will help all our seniors get the proper treatment they need and deserve. It is a reality for North Carolina's communities and our elderly," said Lieutenant Governor Beverly Perdue, Chair of the Health and Wellness Trust Fund Commission.

Funded organizations will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for Senior Care will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under this initiative, 23 new and existing community-based programs were selected by the Commission to receive a total of approximately $3 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to respond to area health needs.

The Health and Wellness Trust Fund Commission was established by the General Assembly to receive and allocate 25% of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The Commission is comprised of 18 individuals representing a wide background of health care experience throughout North Carolina.

AZ

Black Mountain News
Black Mountain, NC
D - 3,550 S - NO DATA
November 21, 2002
Carolina Clipping Service
Raleigh, NC 27603

143

Community Notes

Local organizations awarded impressive prescription assistance grant for seniors

From Staff Reports

The North Carolina Health and Wellness Trust Fund Commission tannounced a grant of $396,000 to Mission St. Joseph for prescription assistance services covering Buncombe, Madison, Yancey and Mitchell counties. The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is a unique feature of our state's prescription drug benefit program, "Senior Care." Seniors especially need help paying for their prescription drugs, but this grant also will help all our seniors get the proper treatment they need and deserve. It is a real win for North Carolina's communities and our elderly," said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fund Commission.

Funded organizations will contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. Seniors who are eligible for "Senior Care" will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under the initiative, 23 new and existing community-based programs were selected by the commission to receive a total of approximately $3 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to respond to area health needs.

The Health and Wellness Trust Fund Commission was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multibillion dollar national tobacco settlement agreement reached in 1999. The commission is comprised of 18 individuals representing a wide background of health care experience throughout North Carolina.

Carolina Times
Durham, NC
D - 5,823 S - NO DATA
December 7, 2002
Carolina Clipping Service
Raleigh, NC 27603

142

Local Organization Awarded Prescription Assistance Grant for Seniors

RALEIGH - The North Carolina Health and Wellness Trust Fund Commission Nov. 7 announced a grant of $208,000 to Senior PHARMAssist, Inc. for prescription assistance services covering Durham County. The grant will provide assistance to seniors and low-income individuals of all ages in acquiring free, low cost or discounted medications. In addition, any senior can receive counseling on the safe and wise use of prescription drugs.

"Educating seniors about appropriate drug use is feature of our State's prescription drug benefit program, *Senior Care*. Seniors especially need help for their prescription drugs, but this grant also will help people of any age who cannot afford their medication. This innovative medical management program will help all our seniors get the proper treatment they need and deserve. It is real win for North Carolina's communities and our elderly." Said Lieutenant Governor Beverly Perdue, chair of the Health and Wellness Trust Fun Commission.

Funded organizations will contract with local pharmacist to counsel seniors in identifying drug utilization issues such as drug-to-drug interaction and duplicative therapies. Seniors who are eligible for Senior Care will receive counseling services at no cost. Other seniors will be able to use the service through payment of a minimal fee, based upon ability to pay.

Under this initiative, 23 new and existing community-based programs were selected by the Commission to receive a total of approximately $5 million annually. In awarding these grants, the Commission gave priority to organizations proposing to serve diverse populations, ensured geographic dispersion, and building capacity within local communities to respond to area health needs.

The Health and Wellness Trust Fund was established by the General Assembly to receive and allocate 25% of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999. The Commission is comprised of 18 individual representing a wide background of health care experience throughout North Carolina.

$8 million in grants announced to combat teen tobacco use

Winston – Salem Chronicle
Winston – Salem, NC
D – 5,818 S – NO DATA
August 29, 2002

SPECIAL TO THE CHRONICLE

The Health and Wellness Trust Fund Commission has announced the availability of $8 million in grants for community-based programs to dissuade North Carolina teens from using tobacco products.

These grants constitute the initial phase of an $18.6 million, three-year initiative that will employ multiple strategies to promote tobacco prevention and cessation among teens statewide.

"We're breaking new ground by investing state resources on this issue in North Carolina," said Lt. Gov. Beverly Perdue, who chairs the commission. "People understand that teens are a vulnerable segment of the population, and that with nearly 40 percent of North Carolina high school students already using tobacco, it is a problem that must be addressed right now."

According to the Centers for Disease Control (CDC), more than 90 percent of first-time tobacco use occurs before age 20, with the average age of initiation being 13. The health effects of prolonged tobacco use among the general population are well documented, and studies by the CDC show that African-Americans suffer disproportionately high rates of heart disease, stroke and lung cancer.

The commission has followed the CDC's guidelines in structuring its overall plan, which includes the effective use of media as well as cessation services and programs designed to help teens who want to quit using tobacco be successful.

The commission last week released two separate requests for proposals. The Community/Schools Prevention Programs Initiative will award between 20 and 30 grants, at an annual level of $25,000 to $100,000 each for three years, for local coalitions capable of organizing and managing tobacco prevention programs for teens. These coalitions will be made up of entities such as schools, public health agencies, local governments, faith-based organizations, state agencies and nonprofit organizations.

Additionally, the Priority Populations Initiative will provide $700,000 annually for three years, to fund three organizations or partnerships capable of projecting statewide reach to address disparities in the use of tobacco by African-American, Native American and Hispanic/Latino youths in North Carolina.

Applicants can obtain a copy of both requests for proposals and application forms online at www.HWTFC.org or by contacting the commission directly.

The Health and Wellness Trust Fund was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multibillion dollar national tobacco settlement agreement reached in 1999. The commission is made up of 18 individuals representing a wide background of health-care experience throughout North Carolina.

N.C. settlement money targets youth tobacco usage

By Herbert L. White
THE CHARLOTTE POST

Part of an N.C. grant to curb teen tobacco use specifically targets African Americans.

The Health and Wellness Trust Fund Commission has made available $8 million in grants for community-based programs to dissuade teens from using tobacco products. The grants constitute the first phase of an $18.6 million, three-year initiative. "We're breaking new ground by investing state resources on this issue in North Carolina," said Lt. Gov. Beverly Perdue, who chairs the commission. "People understand that teens are a vulnerable segment of the population, and that with nearly 40 percent of North Carolina high school students already using tobacco, it is a problem that must be addressed right now."

Perdue

The Health and Wellness Trust Fund was established by the General Assembly to receive and allocate 25 percent of North Carolina's share of the multi-billion dollar national tobacco settlement agreement reached in 1999.

According to the U.S. Centers for Disease Control, over 90 percent of first-time tobacco use occurs before age 20, with the average age of initiation being 13. The health effects of prolonged tobacco use among the general population are well documented, and studies by the CDC show that African Americans suffer dis-

Please see GRANTS/6A

Continued from page 1A

proportionately high rates of heart disease, stroke and lung cancer. The Commission has followed the CDC's guidelines in structuring its overall plan, which includes the effective use of media as well as cessation services and programs designed to help teens who want to quit using tobacco be successful.

The commission has released two requests for proposals. The Community/Schools Prevention Programs Initiative will award up to 30 grants ranging from $25,000 to $100,000 each for three years, for local coalitions to manage tobacco prevention programs.

The Priority Populations Initiative will provide $700,000 annually for three years, to fund three organizations or partnerships capable of projecting statewide reach to address disparities in the use of tobacco by African-American, Native American and Latino kids.

Applicants can obtain a copy of both requests for proposals and applications online at www.HWTFC.org

Charlotte Post
Charlotte, NC
D - 16,900 S - NO DATA
August 29, 2002
Carolina Clipping Service
Raleigh NC 27612

Opinion

Published on: 2002-12-29

A Good Start

State finally begins anti-smoking efforts

Tobacco has put a lot of North Carolina's children through school. It's put food on the table, kept a roof over countless heads. Since King Cotton died, tobacco has been Tar Heel farmers' last best chance at survival; and in some parts of the state, cigarette manufacturers remain one of the major industries.

So it's little wonder that this state has long wrestled with the issue of smoking-cessation programs, and almost invariably, tobacco won. But as tobacco production declines and science paints an increasingly accurate picture of tobacco's impact on human health, North Carolina finally is joining other states in efforts to prevent our children from becoming smokers. It's a modest start, but at this point, any effort is welcome, and any start at all is a positive step.

The N.C. Health and Wellness Trust Fund Commission has given 31 grants, worth nearly $9 million, for programs designed to prevent teen smoking. The bulk of the grants went to 27 local groups - school districts, health departments and community organizations. About $2.2 million will fund efforts to reach African American, Hispanic and American Indian teens. The fund also will spend $1.2 million a year on anti-smoking media efforts and $500,000 a year for additional enforcement of laws prohibiting sale of tobacco to minors.

Credit for the anti-smoking effort goes to Lt. Gov. Beverly Perdue, who chairs the Health and Wellness Fund and who is the first major political figure in the state to make a successful effort to fund anti-smoking programs.

The fund receives 25 percent of the state's proceeds from the national tobacco settlement, and until now, it's been a major embarrassment that none of it has been used to fund smoking-cessation efforts. The new programs are a welcome change, but can't be seen as anything more than a starter, a door-opener. This state loses huge sums every year to the health costs related to smoking, and as other states have already learned, large and aggressive stop-smoking programs pay great dividends in reduced health-care costs and less lost time among employees.

We applaud the Health and Wellness Trust Fund's first anti-smoking initiative, and urge the fund to pursue more aggressive programs in the future.

Copyright 2002 The Fayetteville (N.C.) Observer
Contact Us

THE NEWS & OBSERVER
SUNDAY, DECEMBER 1, 2002

Up in smoke

The poverty of anti-smoking programs is unsettling as other uses are found for the national tobacco settlement's millions.

Billions due from the national legal settlement with tobacco companies — once widely believed to be the ticket to a smoke-free America — turn out to be a slush fund. Only three of the 46 states that signed the deal are spending significant amounts of their payments to cut tobacco use and reduce smoking-related disease, according to a recent N&O article.

Instead, the money is defraying legal costs from a Los Angeles police scandal, financing a video history of tobacco growing in North Carolina and buying a sprinkler system for a public golf course in upstate New York, to cite a few examples.

Squandered resources are always disturbing. But the mass defection from the settlement's purposes is more upsetting because, to receive those payments, the states traded off their rights and those of their localities to sue cigarette companies for the damage caused by smoking.

The consolation for losing that option might have been that the industry would help pay to prevent future suffering. That hasn't happened as quickly as many had hoped, largely because a faltering economy has sent state tax revenues plummeting and politicians scrambling to keep services up and running.

Yet if the nation's poorest state, Mississippi, can provide adequate funding for smoking prevention, as can Maine and Minnesota, it's a mystery why North Carolina and others can't. A commitment is needed from state leaders to increase funding regularly until health officials can mount a truly aggressive campaign.

Half of North Carolina's share of the settlement money goes to the Golden LEAF Foundation, which makes grants to develop economic alternatives to tobacco. The other half of the money is split between tobacco growers and the Health and Wellness Trust Fund, which has been spending it to help seniors pay for prescription drugs. Those are worthwhile programs, but until now, anti-smoking programs have been an after-thought.

At last, the current budget sets aside $6.2 million from the settlement for prevention, as budgets for the next two years also are expected to do. And the state is receiving another $3.2 million from federal and private sources for anti-smoking efforts. While that's better than many states have done, it's a fraction of the $43 million minimum funding recommended by the Centers for Disease Control.

Nor has North Carolina chosen to raise its cigarette tax, a move that 19 other states have made this year, from its extremely modest 5 cents per pack. Higher prices could well have helped depress smoking rates among young people with less money to burn. Instead, it's estimated that 38,000 Tar Heel teenagers take up smoking every year.

In fact, cigarette sales have fallen nationally, due in some measure to tax hikes. Under terms of the settlement, declining sales are expected to reduce the payment to the state by 17 percent next year. North Carolina loses all the way around. For the state to be a winner, our leaders must renew their resolve to awaken people to the dangers of smoking and to relieve economic dependence on tobacco. Their example then would be one for other states to follow.

N+O
12/30/02

Policy smoke signals

Stipulated: North Carolina residents will benefit by a decision by the Health and Wellness Trust Fund Commission to spend $3 million a year on programs to combat obesity. Like the rest of the nation, residents here are adding pounds at a dangerous rate, especially children.

Raising awareness of the serious, long-term health dangers of obesity and reversing the trend will add years to North Carolinians' lives and can save untold tax dollars that otherwise would be spent on treating diabetes, stroke, heart ailments and other illnesses caused by overeating.

Yet the commission fails the state by spending far too little on stop-smoking efforts. Indeed, smoking-related health problems should be the point of the commission. The legislature created it as a result of North Carolina's 1998 settlement with tobacco companies, and designated 25 percent of the $4.6 billion the state will receive over 25 years as its funding source.

Maybe the commission would have spent more than $18.6 million on stop-smoking programs so far had Governor Easley not taken part of its proceeds last year to close a budget shortfall. That should discourage state legislators, hunting for money to fill another big budget hole next year, from raiding the fund again. Doing so defeats its purpose. Trust fund commissioners also dedicated $105 million last year to a three-year prescription drug program for the elderly. Ideally, that important benefit would have come out of the national treasury — and could have been a more robust program had Congress and the Bush administration made it a priority.

Still, smoking prevention and cessation needs to be a focus for state government. The U.S. Centers for Disease Control and Prevention says smoking costs North Carolina $4.75 billion annually in health-care expenses and lost productivity. More than 24,000 North Carolina children become regular, daily smokers each year, which surpasses the national rate. The CDC estimates the state needs to spend at least $43 million a year on tobacco-control efforts.

Stipulated: Lt. Governor Beverly Perdue's recent prediction — that the trust fund, of which she is the chairwoman, will develop into a policy-making board — is on target. Any public body that controls so large a pot of money inevitably will steer policy. Its members need to consider setting anti-tobacco programs as their North Star.

Obesity war

Panel carries its battle a step further

Recent word of funding commitments to combat obesity comes appropriately at a time when many individuals are contemplating personal resolutions to the same end. It's appropriate, not just because it's New Year's, but because it's serious business.

The state Health and Wellness Trust Fund Commission recently placed obesity prevention on its list of projects. The commission, which acts as steward for funds coming to the state from its share of the national tobacco settlement, has earmarked a small portion of this money — $3 million a year — for obesity-fighting projects and another $1 million for research. The commission's move follows recent warnings from both the federal Centers for Disease Control and Prevention and the state Division of Public Health about growing national concerns over obesity.

The CDC says the percentage of overweight children has doubled in the last 20 years.

These sources indicate that obesity contributes to as many as 300,000 premature deaths each year. Being overweight increases chances for diabetes, heart disease, stroke, high blood pressure and cancer. A CDC study out this week reports that both obesity and diabetes rates nationally continued to climb in 2001.

According to the state health department, 60 percent of North Carolina adults are overweight or obese. And a recent East Carolina University test showed that 55 percent of all fourth-graders in one eastern North Carolina county were either overweight or obese. The CDC says the percentage of overweight children has doubled in the last 20 years.

The commission is doing the right thing to target this problem, although in light of these statistics the question might be asked: Is it enough? And this question becomes more ominous when we think of the weight-related problems burgeoning among children. It's problem enough when adults must fight to stay healthy, but the ramifications of a generation or more of overweight and unhealthy children are more than sobering.

As the commission gets down to specifics over the next few months to decide exactly how to use this funding, its challenge will be to find approaches that are dramatic and aggressive. It's easy to talk about losing weight and being healthy. But as anyone who has ever resolved at New Year's to get fit, it's quite another thing to just do it.

The commission's work can help with this struggle.

CITIZEN-TIMES NEWSROOM

Submit a News Tip

Ethics Policy

Write a Letter to the Editor

FEEDBACK

E-mail the newsroom

Questions or Comments about CITIZEN-TIMES.com

State's trust fund money well-spent on battling growing obesity in kids

By Asheville Citizen-Times
POSTED: Jan. 3, 2003 3:21 p.m.

There is no greater health problem in the United States than obesity. Teaching young people the importance of weight control and exercise is a smart use of $3 million in state Health and Wellness Trust Fund money.

Nearly two out of every three adults, 64 percent, were overweight in 2000, according to the National Center for Health Statistics. Nearly half that group, or 31 percent of the total, was obese. A person 5-feet-7 is overweight at 160 pounds and obese at 192 while someone 5-feet-11 is overweight at 179 and obese at 215.

In North Carolina, nearly 60 percent of adults are overweight, according to the state Health Department.

That is a bit better than the national figure, but nothing to brag about. "The problem keeps getting worse," said Tommy G. Thompson, secretary of the U.S. Department of Health and Human Services. "We've seen a virtual doubling in the number of obese persons over the past two decades and this has profound health implications."

Among the health risks associated with obesity are high blood pressure, high cholesterol, Type 2 diabetes and other insulin-related problems, heart disease, stroke, gallstones, gout, osteoarthritis, respiratory problems, some cancers, complications of pregnancy, female reproductive problems, bladder control problems, kidney disorders and psychological problems.

"Overweight and obesity may soon cause as much preventable disease and death as cigarette smoking," said Surgeon General David Satcher. "People tend to think of overweight and obesity as strictly a personal matter, but there is much that communities can and should do to address these problems."

Some 300,000 U.S. deaths a year are associated with obesity and overweight, as compared with more than 400,000 associated with cigarette smoking. The total direct and indirect costs attributable to overweight and obesity in 2000 amounted to $117 billion.

The weight figures for children, as measured by the Centers for Disease Control and Prevention growth charts, may sound better, in that only 15 percent of children are overweight, but they aren't, because the trend is alarming. This is three times the percentage in 1980.

More than 10 percent of preschoolers older than age 2 are overweight. Rates of 20 percent or more are reported for Mexican-American and African-American

school-age children.

"One of the most significant concerns from a public health perspective is that we know a lot of children who are overweight grow up to be overweight or obese adults, and thus at greater risk for some major health problems," said Dr. Julie Gerberding, CDC director. "One critical answer to this problem is that we all must work together to help our children make physical activity a life-long habit."

That is how Laurel Broadbent, a Weaverville physician, hopes most of the $3 million in state trust-fund money, which comes from the national tobacco settlement, will be used. "If those of us in our 40s don't know better by now, you're not going to reach us," she said. "But you can catch the next generation."

The state Public Health Division is leading a Healthy Weight Initiative seeking to get children to exercise more and eat sensibly.

In addition to the $3 million to combat obesity, the Health and Wellness Trust Fund Commission plans to spend $1 million a year for two years on research, said Dr. Charles Wilson, a medical professor at East Carolina University and a commission member. Broadbent says she hopes some of that money will be used to seek causes.

"I'm not saying we'll ever find a pill that will prevent or cure it, but we may understand why some people are more prone to it than others, and intervene before it becomes a threat to health."

Some people undoubtedly are obese due to a genetic or medical condition, but in most case it is simply because they eat too much and don't exercise enough. Saying that, however, does not mean that losing weight and keeping it off is simply a matter of willpower. Guidelines issued by the National Institutes of Health stress the importance of behavioral therapy in treating obesity, and in some cases recommend medications or surgery.

The trust fund commission has been basically a grant-making agency,but its chairman, Lt. Gov. Beverly Perdue, wants to see it making policy decisions. "You'll see the commission, I believe ... trying to lead the state in the conversation and the decision-making about health care and health status of our citizens."

Given the perils posed by the obesity epidemic, reaching out to North Carolina's young is an excellent place to start.

TOOLS: Back Email Print

N&O 12/26/02

Health fund wants state to slim down

Fighting obesity is priority in 2003

By Lynn Bonner
STAFF WRITER

The Health and Wellness Trust Fund Commission has placed preventing obesity and protecting its money at the top of its 2003 priority list.

The decision to set aside $3 million a year for projects aimed at combating obesity and an additional $1 million for research comes as the commission continues to refine its goals.

Its two major commitments, a three-year, $105 million prescription drug program for the elderly and a three-year, $18.6 million plan to combat youth smoking, will eat up most of the available money for the next few years.

The trust fund receives 25 percent of the money coming to the state from the national tobacco settlement. The commission's job is to use a portion of that money to dispense grants to health programs and state agencies. But its chairwoman, Lt. Gov. Beverly Perdue, wants the commission to be more than a group that hands out checks.

"You'll see the commission, I believe, become also a policy board in terms of trying to lead the state in the conversation and the decision-making about health care and health status of our citizens," she said.

With the decision to spend money to combat obesity, the commission joins several state and national agencies pushing weight loss as a health priority. The federal Centers for Disease Control and Prevention and the state Division of Public Health have been warning about health risks associated with obesity, such as heart disease and a form of diabetes.

The Public Health Division is leading a Healthy Weight Initiative aimed at getting children to exercise more and eat healthy food. Nearly 60 percent of North Carolina adults are overweight or obese, according to the state health department. The CDC says the percentage of overweight children has doubled in the past 20 years.

Within the next few months, commission members will discuss how they will use the trust fund to tackle obesity. In addition, the commission will spend

SEE **HEALTH FUND**, PAGE 10B

HEALTH FUND

CONTINUED FROM PAGE 1B

$1 million a year for two years on research, said Dr. Charles Willson, a commission member who is on the medical school faculty at East Carolina University in Greenville.

The commission hasn't decided what kinds of research to support, but Willson said the grants could yield important information about health problems related to lifestyle.

"There are definitely some things that could be done for less than $1 million," he said. "If we could link the obesity project to research as well, I think that we could really have something that could really be fruitful."

As the commission drafts its blueprint, the weight of the state's financial problems — and the possibility that the commission could lose control of some of the trust fund money — hangs around its neck.

Last April, Gov. Mike Easley intercepted $30 million headed for the trust fund to help close the state's budget gap. Legislators scrounging for money to address next year's shortfall might turn again to the trust fund, or the interest building in its account, to help shore up the budget.

Perdue told the commission members that they will soon begin another campaign to persuade the legislature to stay out of the trust fund account.

"We have to start this battle all over again, y'all," she said.

Staff writer Lynn Bonner can be reached at 829-4821 or at lbonner@newsobserver.com.

N+O 12/26/02

Health fund wants state to slim down

Fighting obesity is priority in 2003

By Lynn Bonner
STAFF WRITER

The Health and Wellness Trust Fund Commission has placed preventing obesity and protecting its money at the top of its 2003 priority list.

The decision to set aside $3 million a year for projects aimed at combating obesity and an additional $1 million for research comes as the commission continues to refine its goals.

Its two major commitments, a three-year, $105 million prescription drug program for the elderly and a three-year, $18.6 million plan to combat youth smoking, will eat up most of the available money for the next few years.

The trust fund receives 25 percent of the money coming to the state from the national tobacco settlement. The commission's job is to use a portion of that money to dispense grants to health programs and state agencies. But its chairwoman, Lt. Gov. Beverly Perdue, wants the commission to be more than a group that hands out checks.

"You'll see the commission, I believe, become also a policy board in terms of trying to lead the state in the conversation and the decision-making about health care and health status of our citizens," she said.

With the decision to spend money to combat obesity, the commission joins several state and national agencies pushing weight loss as a health priority. The federal Centers for Disease Control and Prevention and the state Division of Public Health have been warning about health risks associated with obesity, such as heart disease and a form of diabetes.

The Public Health Division is leading a Healthy Weight Initiative aimed at getting children to exercise more and eat healthy food. Nearly 60 percent of North Carolina adults are overweight or obese, according to the state health department. The CDC says the percentage of overweight children has doubled in the past 20 years.

Within the next few months, commission members will discuss how they will use the trust fund to tackle obesity. In addition, the commission will spend

SEE **HEALTH FUND**, PAGE 10B

HEALTH FUND

CONTINUED FROM PAGE 1B

$1 million a year for two years on research, said Dr. Charles Willson, a commission member who is on the medical school faculty at East Carolina University in Greenville.

The commission hasn't decided what kinds of research to support, but Willson said the grants could yield important information about health problems related to lifestyle.

"There are definitely some things that could be done for less than $1 million," he said. "If we could link the obesity project to research as well, I think that we could really have something that could really be fruitful."

As the commission drafts its blueprint, the weight of the state's financial problems — and the possibility that the commission could lose control of some of the trust fund money — hangs around its neck.

Last April, Gov. Mike Easley intercepted $30 million headed for the trust fund to help close the state's budget gap. Legislators scrounging for money to address next year's shortfall might turn again to the trust fund, or the interest building in its account, to help shore up the budget.

Perdue told the commission members that they will soon begin another campaign to persuade the legislature to stay out of the trust fund account.

"We have to start this battle all over again, y'all," she said.

Staff writer Lynn Bonner can be reached at 829-4821 or at lbonner@newsobserver.com.

NORTH CAROLINA GENERAL STATUTES

Chapter 147

Article 6C.

Health and Wellness Trust Fund.

§ 147-86.30. Health and Wellness Trust Fund established.

(a) Fund Established. - There is established the Health and Wellness Trust Fund in the Office of the State Treasurer that shall be used to develop a comprehensive plan to finance programs and initiatives to improve the health and wellness of the people of North Carolina. As used in this Article, the term "Fund" means the Health and Wellness Trust Fund. It is the intent of the General Assembly that the funds provided pursuant to this Article to address the health needs of North Carolinians be used to supplement, not supplant, existing funding of health and wellness programs.

(b) Fund Earnings, Assets, and Balances. - The State Treasurer shall hold the Fund separate and apart from all other moneys, funds, and accounts. The State Treasurer shall be the custodian of the Fund and shall invest its assets in accordance with G.S. 147-69.2 and G.S. 147-69.3. Investment earnings credited to the assets of the Fund shall become part of the Fund. Any balance remaining in the Fund at the end of any fiscal year shall be carried forward in the Fund for the next succeeding fiscal year. Payments from the Fund shall be made on the warrant of the chair of the Commission, pursuant to directives of the Commission. The Commission may expend moneys in the Fund only as provided in subsections (c) and (d) of this section.

(c) Creation of Fund Reserve. - The Commission shall reserve, and shall not expend, fifty percent (50%) of each annual payment allocated to the Health and Wellness Trust Fund pursuant to G.S.143-16.4 during years 2001 through 2025 to create and build the Fund Reserve. During years 2001 through 2025, the Commission may expend any investment earnings on the reserved funds. Beginning in year 2026, and thereafter, the Commission shall not expend the reserved funds but may continue to expend any investment earnings on the reserved funds.

(d) Use of Nonreserved Funds. - The Commission may expend all of the annual payments for years 1998, 1999, and 2000 and may expend the remaining fifty percent (50%) portion of each annual payment thereafter through the year 2025 that is not reserved pursuant to subsection (c) of this section. Any unexpended or unencumbered portion of the nonreserved portion of each annual payment for years 2001 through 2025 that has not been expended or encumbered by the third June 30th following the date of the receipt of the payment shall be reserved pursuant to subsection (c) of this section. The Commission may expend any investment earnings on the nonreserved funds in the year in which the investment earnings are received by the Fund.

(e) Fund Purposes. - Moneys from the Fund may be used for any of the following purposes:

(1) To address the health needs of vulnerable and underserved populations in North Carolina.
(2) To fund programs and initiatives that include research, education, prevention, and treatment of health problems in North Carolina and to increase the capacity of communities to respond to the public's health needs.
(3) To develop a comprehensive, community-based plan with goals and objectives to improve the health and wellness of the people of North Carolina with a priority on preventing, reducing, and remedying the health effects of tobacco use and with an emphasis on reducing youth tobacco use. The plan shall include measurable health and wellness objectives and a proposed timetable for achieving these objectives. In developing the plan, the Commission shall consider all facets of health, including prevention, education, treatment, research, and related areas.

(f) Limit on Operating and Administrative Expenses. - No more than two and one-half percent (2 1/2%) of the annual receipts of the Fund for the fiscal year beginning July 1 or a total sum of one million dollars ($1,000,000), whichever is less, may be used each fiscal year for administrative and operating expenses of the Commission and its staff. All administrative expenses of the Commission shall be paid from the Fund. (2000-147, s. 2.)

§ 147-86.31. Health and Wellness Trust Fund; eligibility for grants; annual reports from non-State agencies.

(a) Eligible Grant Applicants. - Any of the following are eligible to apply for a grant from the Fund:
- (1) A State agency.
- (2) A local government or other political subdivision of the State or a combination of such entities.
- (3) A nonprofit corporation which has as a significant purpose promoting the public's health, limiting youth access to tobacco products, or reducing the health consequences of tobacco use.

(b) Annual Report From Non-State Agencies. - Grant or financial assistance recipients that are non-State agencies shall submit an annual report to the Commission. The report shall include information concerning how the funds are used, the intended goals and objectives of the recipient's grant proposal or program initiative, and the results of an evaluation of the extent to which the outcomes of the initiatives or proposal achieved those goals and objectives. (2000-147, s. 2.)

§ 147-86.32. Health and Wellness Trust Fund; Commission established; membership qualifications; vacancies.

(a) Commission Established. - There is established the Health and Wellness Trust Fund Commission. As used in this Article, the term "Commission" means the Health and Wellness Trust Fund Commission. The Commission shall exercise its powers independently, but for administrative purposes, the Commission shall be located within the Office of the State Treasurer.

(b) Membership. - The Commission shall consist of 18 members. The members shall not be employed by or be agents of tobacco product manufacturing companies. The Commission shall be appointed as follows: six members by the Governor, six members by the President Pro Tempore of the Senate, and six members by the Speaker of the House of Representatives. These members shall be appointed as follows:

(1) The Governor shall make the following appointments:
- a. A person involved in public health.
- b. A person involved in the operation of health care delivery systems.
- c. A health care practitioner.
- d. An at-large appointee.
- e. An at-large appointee.
- f. An at-large appointee.

(2) The President Pro Tempore of the Senate shall make the following appointments:
- a. A person involved in health research.
- b. A person involved in tobacco-related health care issues.
- c. A person involved in health promotion and disease prevention.
- d. An at-large appointee.
- e. An at-large appointee.
- f. An at-large appointee.

(3) The Speaker of the House of Representatives shall make the following appointments:
- a. A person involved in health policy trends.
- b. A person involved with health care for underserved populations.
- c. A person involved with child health care.
- d. An at-large appointee.
- e. An at-large appointee.
- f. An at-large appointee.

It is the intent of the General Assembly that the appointing authorities, in appointing members, shall appoint members who represent the geographic, political, gender, and racial diversity of the State.

(c) Initial Appointments; Term Limits; Officers. - To provide for a staggered membership, the members initially appointed pursuant to sub-subdivisions (b)(1)a., (1)b., (2)d., and (3)d. of this section shall serve one-year terms ending on June 30, 2001. The members initially appointed pursuant to sub-subdivisions (b)(2)c., (2)e., (3)a., and (3)e. shall serve two-year terms ending on June 30, 2002. The members initially appointed pursuant to sub-subdivisions (b)(1)c., (1)d., (1)e., (2)b., and (3)c. shall serve three-year terms ending June 30,
2003. The remaining members initially appointed pursuant to subsection (b) of this section shall serve four-year terms ending June 30, 2004.

Except as provided for the initial members under this subsection, members shall serve four-year terms beginning July 1. No member may serve more than two full consecutive terms. Members may continue to serve beyond their terms until their successors are duly appointed, but any holdover shall not affect the expiration date of the succeeding term. A member may be removed from the Commission for cause by the authority that appointed the member.

The Commission shall elect from its membership a chair, vice-chair, and other officers as necessary for two-year terms beginning July 1 at the first meeting of the Commission held on or after July 1 of every even-numbered year. The vice-chair may act for the chair in the absence of the chair as authorized by the Commission.

(d) Vacancies. - Vacancies shall be filled by the designated appointing authority for the remainder of the unexpired term.

(e) Frequency of Meetings. - The Commission shall meet at least twice each year and may hold special meetings at the call of the chair or a majority of the voting members. The Governor shall call the initial meeting of the Commission.

(f) Quorum; Majority. - Ten members shall constitute a quorum of the Commission. The Commission may act upon a majority vote of all the members of the Commission on matters involving the disbursement of funds and personnel matters properly before the Commission. On all other matters, the Commission may act by majority vote of the members of the Commission at a meeting at which a quorum is present.

(g) Meeting Facilities. - The Office of the State Treasurer shall provide meeting facilities for the Commission and its staff as requested by the chair of the Commission.

(h) Per Diem and Expenses. - The members of the Commission shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5. Per diem, subsistence, and travel expenses of the members shall be paid from the Fund.

(i) Conflict of Interest. - The members of the Commission shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest. In addition to the restrictions imposed under G.S. 14-234, a member shall not vote on, participate in the deliberations of, or otherwise attempt through his or her official capacity to influence the vote on a grant or other financial assistance award by the Commission to a nonprofit entity of which the member is an officer, director, or employee or to a governmental entity of which the member is an employee or a member of the governing board. A violation of this subsection is a Class 1 misdemeanor. (2000-147, s. 2.)

§ 147-86.33. Health and Wellness Trust Fund; powers and duties.

(a) The Commission shall do the following:

(1) Allocate moneys from the Fund as grants. A grant may be awarded only for a program or initiative that satisfies the criteria and furthers the purposes of this Article, but the provisions of this Article shall be liberally construed. The Commission shall strive to avoid imposing any unnecessary barriers in the grant application process.

(2) Develop criteria for awarding grants under this Article. The criteria shall include types of programs and initiatives to be funded, including programs which address the short- and long-term health and wellness of the citizens of North Carolina.

(3) Develop criteria by which to measure the outcomes of funded programs to evaluate the extent to which those programs achieved the goals for which funds were awarded.

(4) Develop a mechanism with which to evaluate individual applications.

(5) Ensure that good faith efforts are made to achieve federal mandates targeting the reduction of youth access to tobacco products.

(6) Administer the provisions of this Article.

(7) Adopt rules to implement this Article.

(b) The Commission is authorized to hire staff or contract for other expertise for the administration of the Fund.

(c) Gifts and Grants. - The Commission is authorized to accept gifts or grants from other sources. (2000-147, s. 2.)

§ 147-86.34. Advisory Council.

The Commission shall create an Advisory Council to advise it with regard to issues as requested by the Commission. The Advisory Council shall include the Secretary of the Department of Health and Human Services, the State Health Director, the Dean of the School of Public Health of the University of North Carolina, and others the Commission considers necessary. (2000-147, s. 2.)

§ 147-86.35. Health and Wellness Trust Fund; reporting requirements.

(a) The chair of the Commission shall report each year by November 1 to the Joint Legislative Commission on Governmental Operations and to the chairs of the Joint Legislative Health Care Oversight Committee regarding implementation of this Article, including a report on funds disbursed during the fiscal year by amount, purpose, and category of recipient, and other information as requested by the Joint Legislative Commission on Governmental Operations. The annual report shall also include a summary of each recipient's annual report submitted to the Health and Wellness Trust Fund Commission pursuant to G.S. 147-86.31(b) and an analysis of progress toward the goals and objectives of any comprehensive, community-based plan established pursuant to G.S. 147-86.30(e)(3). A written copy of the annual report shall also be sent to the Legislative Library by November 1 each year. Written reports shall also be sent on a quarterly basis to the Joint Legislative Commission on Governmental Operations.

(b) Any non-State corporation, organization, or institution that receives, uses, or expends any funds from the Commission is subject to the applicable reporting requirements of G.S. 143-6.1. (2000-147, s. 2.)

§ 147-86.36. Health and Wellness Trust Fund; open meeting and public records requirements.

The Open Meetings Law (Article 33 of Chapter 143 of the General Statutes) and the Public Records Act (Chapter 132 of the General Statutes) shall apply to the Fund and the Commission, and the Fund and the Commission shall be subject to audit by the State Auditor as provided by law. The Commission shall reimburse the State Auditor for the actual cost of the audit. (2000-147, s. 2.)

ELIGIBILITY REQUIREMENTS:
Seniors must qualify for the program based on INCOME, RESIDENCY, DISEASE DIAGNOSIS and AGE. Also, the applicant must not have other prescription drug **insurance** or prescription drug coverage through Medicaid.

INCOME: Applicant must have a total annual income of $17,180 or less if single, and $23,220 or less if married. Applicant must include spouse's income when applying, even if spouse is younger than 65 years of age.

RESIDENCY: Applicant must be a resident of North Carolina.

AGE: Applicant must be 65 years old or older when he/she completes the application.

DISEASE DIAGNOSIS: Applicant must have been diagnosed by a physician with one or more of the following disease conditions:

- Diabetes mellitus (sugar diabetes)
- Hypertension (high blood pressure)
- Angina (chest pain)
- Arrhythmia (irregular heart beat)
- Heart Failure
- Hyperlipidemia (high cholesterol)
- Emphysema
- Chronic bronchitis

HEALTH QUESTIONNAIRE:
Each applicant should fill out the voluntary Health Questionnaire along with the application. This information will be used by the State to track drug interactions, overmedication, therapeutic duplication and inappropriate use. Such cases will be referred to Prescription Assistance Centers throughout the State for prescription and health counseling.

APPLICATION PROCESS:
To request an application by mail, please call our **toll-free hotline** at:

1-866-226-1388

No photocopied applications will be accepted. Applications must be received by the 20th of each month to be eligible for coverage the first day of the following month.

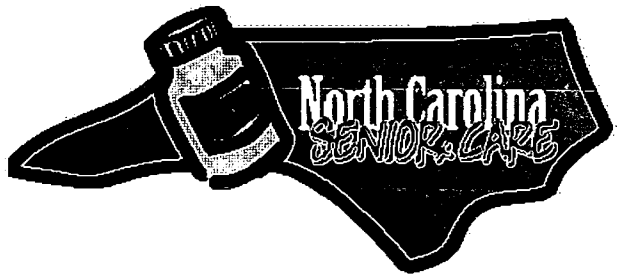
Enrollment occurs year-round, with new program members becoming eligible for benefits on the first day of each month. Re-enrollment occurs annually prior to the anniversary of the initial enrollment. Re-enrollment applications will be mailed directly to current members at the specified re-enrollment date.

Applications should be mailed to the following address:

Office of the Governor
North Carolina Senior Care Program
P.O. Box 10068
Raleigh, NC 27605-5068

North Carolina
Senior Care Program

Helping seniors cope with the rising costs of prescription drugs



QUICK REFERENCE GUIDE

Toll-free Hotline:
1-866-226-1388

Or visit online at:
www.ncseniorcare.com

health & wellness
Trust Fund Commission

ABOUT THE PROGRAM:

The Health and Wellness Trust Commission of North Carolina has contracted with the North Carolina Department of Health and Human Services (DHHS) to administer a prescription drug benefit program for seniors known as the **North Carolina Senior Care Program**. This program is intended to provide access to prescription drugs and insulin for eligible senior citizens of North Carolina.

Senior Care offers a traditional drug benefit program under which the State covers sixty percent of the first one thousand dollars (i.e., up to a maximum State expenditure of $600 per year) of the cost for prescription drugs and insulin for the treatment of cardiovascular disease, chronic obstructive pulmonary disease and/or diabetes. ***It is estimated that one or more of these diseases affects seventy-five percent of the elderly in North Carolina.***

Program members pay the remaining forty percent of the cost for covered drugs, and $6.00 for each 30-day prescription. Any costs beyond the $600 covered by the program, and costs for drugs that treat illnesses not covered by Senior Care, are the member's responsibility.

INCOME DETERMINATION:

Applicants must report their total adjusted gross income (AGI) as shown on their 2001 North Carolina income tax return for themselves and their spouses, as well as any 2001 nontaxable income. Adjusted gross income can be found on form 1040, line 33; form 1040a, line 19; or form 1040ez, line 4. Nontaxable income includes: Social Security, Veterans' benefits and public assistance. Medicare monthly premiums will also need to be added to the Social Security figure. The senior can refer to the letter they receive from the Social Security Administration that states the amount of their monthly Medicare premium.

To determine their income, applicants should total their adjusted gross income and their nontaxable income.

Seniors who were not required to file a tax return due to low income should list their income on line 2 of section 2 of the application.

INTERNET ACCESS:

Detailed program information and an online version of the application form can be found at www.ncseniorcare.com. The application for enrollment can be filled out online, but must be printed, signed, and mailed to the following address: Office of the Governor, North Carolina Senior Care Program, P.O. Box 10068, Raleigh, NC 27605-5068. Applications without a signature cannot be processed.

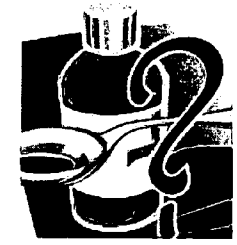
OTHER INSURANCE:

The program is designed for those seniors without prescription benefits.

Discount Cards DO NOT count as insurance, but Medicaid, TriCare, VA or Medicare supplemental policies do.

PROOF OF INCOME, RESIDENCY & AGE:

Applicants are not required to mail documents. They must sign a statement on the application form attesting to their income and residency, which provides consent for the State to use their Social Security number to confirm reported income levels and residency.



VISITOR REGISTRATION SHEET

Health and Human Resources Committee — April 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Burdick	Astra Zeneca
Mary Jeanie	S+B
Ken McHan	Alley Associates, Inc.
Evelyn Hawthorne	DHGR
Virginia Hebert	Sen. Kinnaird
Marion Deerhake	Self
LIZ KANOF MD	NC Medical Society NC Dermatology Assoc
Linda Sewall	DEH, DENR
Kari Barsness	DENR
J. Craig Pierce	UHS
Angie Horne	NCMS
Stacy Flamm	NCHCFA

VISITOR REGISTRATION SHEET

Health and Human Resources Committee — April 9, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Crissy Porter	Smith Anderson
William Johnson	Radiation Protection Section, DENR
Beverly Hall	Radiation Protection Section
[signature]	Radiation Protection Section
Sheila McKernan	NC DHHS
Chris Hoke	NC DHHS
Jennifer M. Sullivan	NASW-NC
Kevin V. Howell	Sen. Forrester
Lauren Newton	Speaker Morgan
Julie Jernigan	Staff - DOT Wangunman

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 16, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, April 16, 2003 in Room 544 of the Legislative Office Building. Ten members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Bingham, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Purcell asked for a motion to suspend the rules to the end that proposed committee substitute bills be made available to the committee members 24 hours in advance of the meeting. Senator Forrester so moved, for the bills to be heard at this meeting, and for all bills between today and crossover, April 24th. The motion passed.

Senator Purcell called on Senator Kerr to present his bill, SB 704, *Traumatic Brain Injury*. Senator Dannelly moved that the proposed committee substitute be adopted for purposes of discussion. The motion passed. He called on Chuck Stone of Goldsboro, who gave a brief summary of the bill's origins. Senator Dannelly asked if a fiscal note is needed to go along with this bill. Carol Lawson of the Department of Mental Health responded that her department is prepared to handle any cost, if need be. Senator Dannelly moved for a favorable report for the committee substitute, unfavorable as to the bill. The motion passed.

Senator Purcell announced that SB 582, *Public Schools/Healthy Kids*, would be removed from today's committee calendar.

Senator Purcell called on Senator Kinnaird to present SB 724, *Discharge from Adult Care Homes* to the Committee, but said that since there was some concern about this bill, that it would be heard, but not voted on in the Committee today. Senator Dannelly moved that the proposed committee substitute be adopted for purposes of discussion. The motion passed. Senator Hoyle asked if the Department of Social Services is not already working on this problem. Senator Kinnaird asked Roger Maness, legal counsel for Friends of Long Term Care to speak. She also asked research staff to go through the committee substitute point by point for the Committee. Senator Dannelly asked if long-term care residents had been discharged for nonpayment or partial payment. The response was yes. In response to a question from Senator Allran, Ms. Jessup said that a provision in this bill would shift the burden to the nursing home or rest home to show that transfer was due to imminent jeopardy.

Senator Rand presented SB 926, *Clarify Group Homes Licensure & LEA Reimburs.* Senator Bingham moved that the proposed committee substitute be adopted for purposes of discussion. The motion passed. Senator Dannelly moved for a favorable report for the proposed committee substitute, unfavorable as to bill. The motion passed and the bill was re-referred to Appropriations.

The meeting adjourned at 11:52 A.M.

William R. Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

REVISED

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
SENATE
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Monday, April 21, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **648** Cervical Cancer Elimination Task Force.

Draft Number:	PCS40019
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

S.B. **704** Traumatic Brain Injury Advisory Council.

Draft Number:	PCS65265
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **876** Meningitis Immunization.

Draft Number:	PCS75241
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **897** Medicaid Prior Authorization.

Draft Number:	PCS85214
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **926** Clarify Group Homes Licensure & LEA reimburs.

Draft Number:	PCS65264
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 5

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Monday, April 28, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **388** Update Cervical Cancer Screening Coverage.

Draft Number:	PCS85220
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 926

Short Title: Clarify Group Homes Licensure & LEA reimburs. (Public)

Sponsors: Senator Rand.

Referred to: Health & Human Resources.

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-140.1 reads as rewritten:

"**§ 115C-140.1. Cost of education of children in group homes, foster homes, etc.**

(a) **(Effective until July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with special needs who is placed in or assigned to a group home, foster home or other similar facility, pursuant to State and federal law, shall be borne by the local board of education in which the group home, foster home or other similar facility is located. Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.

(a) **(Effective July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with ~~special needs~~ disabilities who is placed in or assigned to a group ~~home,~~ home or foster ~~home or other similar facility,~~ home, pursuant to State and federal law, shall be borne by the local board of education in which the group ~~home,~~ home or foster home ~~or other similar facility~~ is located. ~~However, the local school administrative unit in which a child is domiciled shall transfer to the local school administrative unit in which the institution is located an amount equal to the actual local cost in excess of State and federal funding required to educate that child in the local school administrative unit for the fiscal year. Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.~~ Local administrative units may submit a Special State Reserve Program

application for foster home or group home children whose special education and related services costs exceed the per child group home allocation.

(b) The State Board of Education shall use State and federal funds appropriated for children with special needs to establish a reserve fund to reimburse local boards of education for the education costs of children assigned to group homes or other facilities as provided in subsection (a) of this section.

(c) The Department shall review the current cost of children with disabilities served in the local school administrative units with group homes or foster homes to determine the actual cost of services.

(d) Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with disabilities in a group home or foster home."

SECTION 2. G.S. 112C-23 reads as rewritten:

"**§ 122C-23. Licensure.**

(a) No person shall establish, maintain, or operate a licensable facility for the mentally ill, developmentally disabled, or substance abusers without a current license issued by the Secretary.

(b) Each license is issued to the person only for the premises named in the application and shall not be transferable or assignable except with prior written approval of the Secretary.

(c) Any person who intends to establish, maintain, or operate a licensable facility shall apply to the Secretary for a license. The Secretary shall prescribe by rule the contents of the application forms.

(d) The Secretary shall issue a license if the Secretary finds that the person complies with this Article and the rules of the Commission and Secretary.

(e) Unless a license is provisional or has been suspended or revoked, it shall be valid for a period not to exceed two years from the date of issue. The expiration date of a license shall be specified on the license when issued. Renewal of a regular license is contingent upon receipt of information required by the Secretary for renewal and continued compliance with this Article and the rules of the Commission and the Secretary.

A provisional license for a period not to exceed six months may be granted by the Secretary to a person who is temporarily unable to comply with a rule or rules. During this period the licensable facility shall correct the noncompliance based on a plan submitted to and approved by the Secretary. The noncompliance may not present an immediate threat to the health and safety of the individuals in the licensable facility. A provisional license for an additional period of time to meet the noncompliance may not be issued.

(e1) Except as provided in subsection (e2) of this section, ~~The Department~~ the Secretary shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C~~122C, ~~or~~ Chapter 131D or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) Is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of this Chapter ~~until 60 months after the date of the violation.~~until:

a. Six months from the date of the assessment of the violation.

b. Twelve months from the date of the assessment of the second violation if two Type A or Type B violations, or combination thereof, have been assessed in a six-month period.

c. Thirty-six months from the date of the assessment of the third violation if three Type A or Type B violations, or combination thereof, have been assessed in a 12-month period.

d. Sixty months from the date of the assessment of the fourth violation if four Type A or Type B violations, or combination thereof, have been assessed in a 36 month period.

(3) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D until 60 months after the date of reinstatement or restoration of the license.

(5) Is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 130D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated under those statutes and will probably place clients at high risk of danger if the applicant were granted enrollment.

(e1) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(f) Upon written application and in accordance with rules of the Commission, the Secretary may for good cause waive any of the rules implementing this Article, provided those rules do not affect the health, safety, or welfare of the individuals within the licensable facility. Decisions made pursuant to this subsection may be appealed to the Commission for a hearing in accordance with Chapter 150B of the General Statutes.

(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 3. G.S. 131D-2 reads as rewritten:

"**§ 131D-2. Licensing of adult care homes for the aged and disabled.**

(a) The following definitions will apply in the interpretation of this section:

(1) "Abuse" means the willful or grossly negligent infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(1a) "Administrator" means a person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(1b) "Adult care home" is an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

(1c) "Amenities" means services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(1d) "Assisted living residence" means any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home

care or hospice agencies. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. Effective October 1, 1995, there are two types of assisted living residences: adult care homes and group homes for developmentally disabled adults. Effective July 1, 1996, there is a third type, multiunit assisted housing with services.

(1e) "Compensatory agent" means a spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(1f) "Department" means the Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(2) Repealed by Session Laws 2001-209, s. 1(a).

(3) Repealed by Session Laws 1995, c. 535, s. 8.

(4) "Exploitation" means the illegal or improper use of an aged or disabled resident or his resources for another's profit or advantage.

(5) "Family care home" means an adult care home having two to six residents. The structure of a family care home may be no more than two stories high and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(6) Repealed by Session Laws 2001-209, s. 1(b).

(7) Repealed by Session Laws 1995, c. 535, s. 8.

(7a) Effective July 1, 1996, "multiunit assisted housing with services" means an assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency, through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Facility Services and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(8) "Neglect" means the failure to provide the services necessary to maintain a resident's physical or mental health.

(9) "Personal care services" means any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(10) "Registration" means the submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (7a) of this subsection.

(11) "Resident" means a person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(12) "Secretary" means the Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

(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 Medical Care Commission determines cannot be properly met in an adult care home.

(a2) Persons not to be cared for in multiunit assisted housing with services. – 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, multiunit assisted

housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing;

(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this State;

(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold;

(5) Psychotropic medications without appropriate diagnosis and treatment plans;

(6) Nasogastric tubes;

(7) Gastric tubes except when the individual is capable of independently feeding himself and caring for the tube, or as managed by a home care or hospice agency licensed in this State;

(8) Individuals requiring continuous licensed nursing care;

(9) Individuals whose physician certifies that placement is no longer appropriate;

(10) Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment instrument;

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(a3) Hospice care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(b) Licensure; inspections. –

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the 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 for

failure to comply with any part of this section or any rules adopted hereunder. 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 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 provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward 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 Medical Care Commission, for substantial failure to comply with the provisions of this section or rules 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.

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection, the Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. In carrying out this requirement, the Department shall work with county departments of social services to do the routine monitoring and to have the Division of Facility Services oversee this monitoring and perform any follow-up inspection called for. The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit. The Department shall also keep an up-to-date directory of all persons who are administrators as defined in subdivision (1a) of subsection (a) of this section.

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

a. Was the owner, principal, or affiliate of ~~an adult care home~~ a licensable facility under Chapter 122C, Chapter 131D or Article 7 of Chapter 110 that had its license revoked until one full year after the date of revocation;

b. Is the owner, principal, or affiliate 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 owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to

provisional status as a result of Type A or B violations 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.

d. Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the 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.

(2) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor, and upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(3) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a 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 20 days after the Department mails a notice of summary suspension to the licensee.

(4) Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under subsection (b):

a. Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

b. Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives;

unless the resident objects in writing to review of his records or disclosure of such information.

The facility, its employees and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department.

The Department shall not disclose:

a. Any confidential or privileged information obtained under this subsection unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(5) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

(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.

(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;

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or 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.

(c1) Although the contract obligation still remains to pay the housing management for any services covered by the contract between the resident and housing management, the resident of an assisted living facility has the right to obtain services not at the expense of the housing management, from providers other than the housing management.

(c2) The Medical Care Commission shall adopt 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.

(c3) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(c4) Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging, providing information on their location and number of units operated. This type of housing is not considered assisted living.

(d) Repealed by Session Laws 1995, c. 535, s. 8.

(e) The Department shall ensure that facilities conduct and complete an assessment of each resident within seventy-two hours of 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 Director of the Division of 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 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.

(f) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

(g) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

(h) Suspension of admissions to adult care home:

(1) In addition to the administrative penalties described in subsection (b), the Secretary may suspend the admission of any new residents to an adult care home, where the conditions of the adult care home are detrimental to the health or safety of the residents. 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 removing the suspension.

(2) In imposing a suspension under this subsection, the Secretary shall consider the following factors:

a. The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

b. The character and degree of impact of the conditions at the home on the health or safety of its residents.

(3) The Secretary of Health and Human Services shall adopt rules to implement this subsection.

(4) Any facility wishing to contest a suspension of admissions 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 20 days after the Department mails a notice of suspension of admissions to the licensee.

(i) Notwithstanding the existence or pursuit of any other remedy, the Department of Health and Human Services may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

Actions under this subsection shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure."

SECTION 4. G.S. 131D-10.3 reads as rewritten:

"**§ 131D-10.3. Licensure required.**

(a) No person shall operate, establish or provide foster care for children or receive and place children in residential care facilities, family foster homes, or adoptive homes without first applying for a license to the Department and submitting the required information on application forms provided by the Department.

(b) Persons licensed or seeking a license under this Article shall permit the Department access to premises and information required to determine whether the person is in compliance with licensing rules of the Commission.

(c) Persons licensed pursuant to this Article shall be periodically reviewed by the Department to determine whether they comply with Commission rules and whether licensure shall continue.

(d) This Article shall apply to all persons intending to organize, develop or provide foster care for children or receive and place children in residential child-care facilities, family foster homes or adoptive homes irrespective of such persons having applied for or obtained a certification, registration or permit to carry on work not controlled by this Article except persons exempted in G.S. 131D-10.4.

(e) Unless revoked or modified to a provisional or suspended status, the terms of a license issued by the Department shall be in force for a period not to exceed 24 months from the date of issuance under rules adopted by the Commission.

(f) Persons licensed or seeking a license who are temporarily unable to comply with a rule or rules may be granted a provisional license. The provisional license can be issued for a period not to exceed six months. The noncompliance with a rule or rules shall not present an immediate threat to the health and safety of the children, and the person shall have a plan approved by the Department to correct the area(s) of

noncompliance within the provisional period. A provisional license for an additional period of time to meet the same area(s) of noncompliance shall not be issued.

(g) In accordance with Commission rules, a person may submit to the Department documentation of compliance with the standards of a nationally recognized accrediting body, and the Department on the basis of such accreditation may deem the person in compliance with one or more Commission licensing rules.

(h) Except as provided in subsection (i) of this section, the Secretary, ~~The Department~~ shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C or~~ 122C, Chapter 131D or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) Is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of Chapter 122C ~~until 60 months after the date of the violation.~~until:

a. Six months from the date of the assessment of the violation.

b. Twelve months from the date of the assessment of the second violation if two Type A or Type B violations, or combination thereof, have been assessed in a six-month period.

c. Thirty-six months from the date of the assessment of the third violation if three Type A or Type B violations, or combination thereof, have been assessed in a 12-month period.

d. Sixty months from the date of the assessment of the fourth violation if four Type A or Type B violations, or combination thereof, have been assessed in a 36-month period.

(3) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C- 24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D or had its license summarily suspended or denied under Article 7 of Chapter 110 until 60 months after the date of reinstatement or restoration of the license.

(5) Is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 130D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated under those statutes and will probably place clients at high risk of danger if the applicant were granted enrollment.

(i) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed."

SECTION 5. Section 3 of S.L. 2002-164 reads as rewritten:

"**SECTION 3.** The State Board of Education shall provide for a local school administrative unit to request funds from the Group Homes Program for Children with Disabilities if a child assigned to that unit was not in that unit's April ~~headcount~~ childcount for ~~exceptional~~ children with disabilities or the average daily membership for the previous school ~~year, even if the local school administrative unit received Group Homes Program funds for that child for a portion of the preceding school year~~year. The local school administrative unit shall receive full school year funding upon the local school unit's request for group home or foster home program funds. These funds may not be requested except by a local school administrative unit."

SECTION 6(a). The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall report on the following Program information:

(1) The number and other demographic information of children served utilizing Comprehensive Treatment Services Program funds or who are placed out of their home under the auspices of one of the referenced agencies.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened for mental health, developmental disabilities, or substance abuse; specific placement of children including the placement of children in programs or facilities outside of the child's home county; and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.

(6) Recommendations on other areas that need to be improved.

(7) Other information relevant to successfully maintaining children in their county of residence.

(8) A method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings.

SECTION 6(b). The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall submit a report by April 1, 2004, on the method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings to the House of Representatives

Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 7. There is appropriated from the General Fund to the State Aid for Children with Disabilities in the Public School Fund the sum of five hundred thousand dollars ($500,000) for each year of the 2003-2004 fiscal year.

SECTION 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 926
PROPOSED COMMITTEE SUBSTITUTE S926-PCS65264-ST-11

Short Title: Clarify Group Homes Licensure & LEA Reimburs. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-140.1 reads as rewritten:

"**§ 115C-140.1. Cost of education of children in group homes, foster homes, etc.**

(a) **(Effective until July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with special needs who is placed in or assigned to a group home, foster home or other similar facility, pursuant to State and federal law, shall be borne by the local board of education in which the group home, foster home or other similar facility is located. Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.

(a) **(Effective July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with ~~special needs~~ disabilities who is placed in or assigned to a group ~~home,~~ home or foster ~~home or other similar facility,~~ home, pursuant to State and federal law, shall be borne by the local board of education in which the group ~~home,~~ home or foster home ~~or other similar facility~~ is located. However, the local school administrative unit in which a child is domiciled shall transfer to the local school administrative unit in which the institution is located an amount equal to the actual local cost in excess of State and federal funding required to educate that child in the local school administrative unit for the fiscal ~~year.~~ year after all State and federal funding has been exhausted. ~~Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.~~

(b) The State Board of Education shall use State and federal funds appropriated for children with special needs to establish a reserve fund to reimburse local boards of education for the education costs of children assigned to group homes or other facilities as provided in subsection (a) of this section. Local school administrative units may submit a Special State Reserve Program application for foster home or group home children whose special education and related services costs exceed the per child group home allocation.

(c) The Department shall review the current cost of children with disabilities served in the local school administrative units with group homes or foster homes to determine the actual cost of services."

SECTION 2. G.S. 122C-23 reads as rewritten:

"**§ 122C-23. Licensure.**

(a) No person shall establish, maintain, or operate a licensable facility for the mentally ill, developmentally disabled, or substance abusers without a current license issued by the Secretary.

(b) Each license is issued to the person only for the premises named in the application and shall not be transferable or assignable except with prior written approval of the Secretary.

(c) Any person who intends to establish, maintain, or operate a licensable facility shall apply to the Secretary for a license. The Secretary shall prescribe by rule the contents of the application forms.

(d) The Secretary shall issue a license if the Secretary finds that the person complies with this Article and the rules of the Commission and Secretary.

(e) Unless a license is provisional or has been suspended or revoked, it shall be valid for a period not to exceed two years from the date of issue. The expiration date of a license shall be specified on the license when issued. Renewal of a regular license is contingent upon receipt of information required by the Secretary for renewal and continued compliance with this Article and the rules of the Commission and the Secretary.

A provisional license for a period not to exceed six months may be granted by the Secretary to a person who is temporarily unable to comply with a rule or rules. During this period the licensable facility shall correct the noncompliance based on a plan submitted to and approved by the Secretary. The noncompliance may not present an immediate threat to the health and safety of the individuals in the licensable facility. A provisional license for an additional period of time to meet the noncompliance may not be issued.

(e1) Except as provided in subsection (e2) of this section, ~~The Department~~ the Secretary shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C~~122C, ~~or~~ Chapter ~~131D~~131D, or Article 7

of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of this ~~Chapter until 60 months after the date of the violation.~~ Chapter, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D until 60 months after the date of reinstatement or restoration of the license.

(5) The applicant is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated under those statutes.

(e2) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(f) Upon written application and in accordance with rules of the Commission, the Secretary may for good cause waive any of the rules implementing this Article, provided those rules do not affect the health, safety, or welfare of the individuals within

the licensable facility. Decisions made pursuant to this subsection may be appealed to the Commission for a hearing in accordance with Chapter 150B of the General Statutes.

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

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

a. Was the owner, principal, or affiliate of ~~an adult care home~~ a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked until one full year after the date of revocation;

b. Is the owner, principal, or affiliate 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 owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations 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.

d. Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the 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 4. G.S. 131D-10.3 reads as rewritten:

"**§ 131D-10.3. Licensure required.**

(a) No person shall operate, establish or provide foster care for children or receive and place children in residential care facilities, family foster homes, or adoptive homes without first applying for a license to the Department and submitting the required information on application forms provided by the Department.

(b) Persons licensed or seeking a license under this Article shall permit the Department access to premises and information required to determine whether the person is in compliance with licensing rules of the Commission.

(c) Persons licensed pursuant to this Article shall be periodically reviewed by the Department to determine whether they comply with Commission rules and whether licensure shall continue.

(d) This Article shall apply to all persons intending to organize, develop or provide foster care for children or receive and place children in residential child-care facilities, family foster homes or adoptive homes irrespective of such persons having applied for or obtained a certification, registration or permit to carry on work not controlled by this Article except persons exempted in G.S. 131D-10.4.

(e) Unless revoked or modified to a provisional or suspended status, the terms of a license issued by the Department shall be in force for a period not to exceed 24 months from the date of issuance under rules adopted by the Commission.

(f) Persons licensed or seeking a license who are temporarily unable to comply with a rule or rules may be granted a provisional license. The provisional license can be issued for a period not to exceed six months. The noncompliance with a rule or rules shall not present an immediate threat to the health and safety of the children, and the person shall have a plan approved by the Department to correct the area(s) of noncompliance within the provisional period. A provisional license for an additional period of time to meet the same area(s) of noncompliance shall not be issued.

(g) In accordance with Commission rules, a person may submit to the Department documentation of compliance with the standards of a nationally recognized accrediting body, and the Department on the basis of such accreditation may deem the person in compliance with one or more Commission licensing rules.

(h) Except as provided in subsection (i) of this section, the Secretary ~~The Department~~ shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C or~~ 122C, Chapter ~~131D~~131D, or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of ~~Chapter 122C until 60 months after the date of the violation.~~Chapter122C, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C- 24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter ~~131D~~131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until 60 months after the date of reinstatement or restoration of the license.

(5) The applicant is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated.

(i) The Secretary may enroll a provider described in subsection (h) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed."

SECTION 5. Section 3 of S.L. 2002-164 reads as rewritten:

"**SECTION 3.** The State Board of Education shall provide for a local school administrative unit to request funds from the Group Homes Program for Children with Disabilities if a child assigned to that unit was not in that unit's April ~~headcount~~ child count for ~~exceptional~~ children with disabilities or the average daily membership for the previous school ~~year, even if the local school administrative unit received Group Homes Program funds for that child for a portion of the preceding school year~~year. The local school administrative unit shall receive full school year funding upon the local school unit's request for group home or foster home program funds. These funds may not be requested except by a local school administrative unit."

SECTION 6.(a) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall report on the following Program information:

(1) The number and other demographic information of children served utilizing Comprehensive Treatment Services Program funds or who are placed out of their home under the auspices of one of the referenced agencies.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened for mental health, developmental disabilities, or substance abuse; specific placement of children including the placement of children in programs or facilities outside of the child's home county; and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.

(6) Recommendations on other areas that need to be improved.

(7) Other information relevant to successfully maintaining children in their county of residence.

(8) A method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings.

SECTION 6.(b) The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall submit a report by April 1, 2004, on the method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 926
PROPOSED COMMITTEE SUBSTITUTE S926-CSST-11 [v.4]

4/15/2003 5:25:40 PM

Short Title: Clarify Group Homes Licensure & LEA reimburs. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LICENSING PROCESS FOR NEW GROUP HOME FACILITIES AND FOR THE REIMBURSEMENT OF EDUCATIONAL COSTS BY THE HOME COUNTY TO THE HOST COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-140.1 reads as rewritten:

"**§ 115C-140.1. Cost of education of children in group homes, foster homes, etc.**

(a) **(Effective until July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with special needs who is placed in or assigned to a group home, foster home or other similar facility, pursuant to State and federal law, shall be borne by the local board of education in which the group home, foster home or other similar facility is located. Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.

(a) **(Effective July 1, 2003)** Notwithstanding the provisions of any other statute and without regard for the place of domicile of a parent or guardian, the cost of a free appropriate public education for a child with ~~special needs~~ disabilities who is placed in or assigned to a group ~~home,~~ home or foster ~~home or other similar facility,~~ home, pursuant to State and federal law, shall be borne by the local board of education in which the group ~~home,~~ home or foster home ~~or other similar facility~~ is located. However, the local school administrative unit in which a child is domiciled shall transfer to the local school administrative unit in which the institution is located an amount equal to the actual local cost in excess of State and federal funding required to educate that child in the local school administrative unit for the fiscal ~~year.~~ year after all State and federal funding has been exhausted. ~~Nothing in this section obligates any local board of education to bear any cost for the care and maintenance of a child with special needs in a group home, foster home or other similar facility.~~

(b) The State Board of Education shall use State and federal funds appropriated for children with special needs to establish a reserve fund to reimburse local boards of education for the education costs of children assigned to group homes or other facilities as provided in subsection (a) of this section. Local administrative units may submit a Special State Reserve Program application for foster home or group home children whose special education and related services costs exceed the per child group home allocation.

(c) The Department shall review the current cost of children with disabilities served in the local school administrative units with group homes or foster homes to determine the actual cost of services."

SECTION 2. G.S. 122C-23 reads as rewritten:

"**§ 122C-23. Licensure.**

(a) No person shall establish, maintain, or operate a licensable facility for the mentally ill, developmentally disabled, or substance abusers without a current license issued by the Secretary.

(b) Each license is issued to the person only for the premises named in the application and shall not be transferable or assignable except with prior written approval of the Secretary.

(c) Any person who intends to establish, maintain, or operate a licensable facility shall apply to the Secretary for a license. The Secretary shall prescribe by rule the contents of the application forms.

(d) The Secretary shall issue a license if the Secretary finds that the person complies with this Article and the rules of the Commission and Secretary.

(e) Unless a license is provisional or has been suspended or revoked, it shall be valid for a period not to exceed two years from the date of issue. The expiration date of a license shall be specified on the license when issued. Renewal of a regular license is contingent upon receipt of information required by the Secretary for renewal and continued compliance with this Article and the rules of the Commission and the Secretary.

A provisional license for a period not to exceed six months may be granted by the Secretary to a person who is temporarily unable to comply with a rule or rules. During this period the licensable facility shall correct the noncompliance based on a plan submitted to and approved by the Secretary. The noncompliance may not present an immediate threat to the health and safety of the individuals in the licensable facility. A provisional license for an additional period of time to meet the noncompliance may not be issued.

(e1) Except as provided in subsection (e2) of this section, ~~The Department~~ the Secretary shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C~~122C, ~~or~~ Chapter 131D or Article 7 of

Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of this ~~Chapter until 60 months after the date of the violation.~~ Chapter, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D until 60 months after the date of reinstatement or restoration of the license.

(5) The applicant is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated under those statutes.

(e2) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(f) Upon written application and in accordance with rules of the Commission, the Secretary may for good cause waive any of the rules implementing this Article, provided those rules do not affect the health, safety, or welfare of the individuals within

the licensable facility. Decisions made pursuant to this subsection may be appealed to the Commission for a hearing in accordance with Chapter 150B of the General Statutes.

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

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

a. Was the owner, principal, or affiliate of ~~an adult care home~~ a licensable facility under Chapter 122C, Chapter 131D or Article 7 of Chapter 110 that had its license revoked until one full year after the date of revocation;

b. Is the owner, principal, or affiliate 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 owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations 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.

d. Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the 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 4. G.S. 131D-10.3 reads as rewritten:

"**§ 131D-10.3. Licensure required.**

(a) No person shall operate, establish or provide foster care for children or receive and place children in residential care facilities, family foster homes, or adoptive homes without first applying for a license to the Department and submitting the required information on application forms provided by the Department.

(b) Persons licensed or seeking a license under this Article shall permit the Department access to premises and information required to determine whether the person is in compliance with licensing rules of the Commission.

(c) Persons licensed pursuant to this Article shall be periodically reviewed by the Department to determine whether they comply with Commission rules and whether licensure shall continue.

(d) This Article shall apply to all persons intending to organize, develop or provide foster care for children or receive and place children in residential child-care facilities, family foster homes or adoptive homes irrespective of such persons having applied for or obtained a certification, registration or permit to carry on work not controlled by this Article except persons exempted in G.S. 131D-10.4.

(e) Unless revoked or modified to a provisional or suspended status, the terms of a license issued by the Department shall be in force for a period not to exceed 24 months from the date of issuance under rules adopted by the Commission.

(f) Persons licensed or seeking a license who are temporarily unable to comply with a rule or rules may be granted a provisional license. The provisional license can be issued for a period not to exceed six months. The noncompliance with a rule or rules shall not present an immediate threat to the health and safety of the children, and the person shall have a plan approved by the Department to correct the area(s) of noncompliance within the provisional period. A provisional license for an additional period of time to meet the same area(s) of noncompliance shall not be issued.

(g) In accordance with Commission rules, a person may submit to the Department documentation of compliance with the standards of a nationally recognized accrediting body, and the Department on the basis of such accreditation may deem the person in compliance with one or more Commission licensing rules.

(h) Except as provided in subsection (i) of this section, the Secretary, ~~The Department~~ shall not enroll any new provider for Medicaid Home or Community Based services or other Medicaid services, as defined in 42 C.F.R. 440.90, 42 C.F.R. 440.130(d), and 42 C.F.R. 440.180, or issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) ~~Was~~ The applicant was the owner, principal, or affiliate of a licensable facility under Chapter ~~122C or~~ 122C, Chapter 131D or Article 7 of Chapter 110 that had its license revoked until 60 months after the date of the revocation.

(2) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of ~~Chapter 122C until 60 months after the date of the violation.~~Chapter122C, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C- 24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) ~~Is~~ The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D or had its license summarily suspended or denied under Article 7 of Chapter 110 until 60 months after the date of reinstatement or restoration of the license.

(5) The applicant is found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated.

(i) The Secretary may enroll a provider described in subsection (h) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed."

SECTION 5. Section 3 of S.L. 2002-164 reads as rewritten:

"**SECTION 3.** The State Board of Education shall provide for a local school administrative unit to request funds from the Group Homes Program for Children with Disabilities if a child assigned to that unit was not in that unit's April ~~headcount~~ childcount for ~~exceptional~~ children with disabilities or the average daily membership for the previous school ~~year, even if the local school administrative unit received Group Homes Program funds for that child for a portion of the preceding school year~~year. The local school administrative unit shall receive full school year funding upon the local school unit's request for group home or foster home program funds. These funds may not be requested except by a local school administrative unit."

SECTION 6(a). The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall report on the following Program information:

(1) The number and other demographic information of children served utilizing Comprehensive Treatment Services Program funds or who are placed out of their home under the auspices of one of the referenced agencies.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened for mental health, developmental disabilities, or substance abuse; specific placement of children including the placement of children in programs or facilities outside of the child's home county; and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.

(6) Recommendations on other areas that need to be improved.

(7) Other information relevant to successfully maintaining children in their county of residence.

(8) A method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings.

SECTION 6(b). The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, and the Department of Public Instruction shall submit a report by April 1, 2004, on the method of identifying and reporting child placements outside of the family unit in group homes or therapeutic foster care home settings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 7. This act is effective when it becomes law.

SENATE BILL 926:
Clarify Group Homes Licensure & LEA reimburs

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Senator Rand
		Summary by:	R. Erika Churchill Staff Counsel
Date:	April 19, 2003		
Version:	S926-CSST-11 v.4		

SUMMARY: ***The proposed committee substitute would make various clarifying amendments to the licensure statutes for group homes and to the statutes governing reimbursement for the educational costs of children in group homes.***

CURRENT LAW AND BILL ANALYSIS:

Section 1.

Current Law. Payment for the cost of educating children in group homes. G.S. 115C-140.1(a), effective July 1, 2003, provides that the local board of education in which the group home is located is responsible for the cost of a free appropriate public education for a child with special needs residing in a group home or foster home. However, the local school administrative unit where that child is domiciled is to transfer to the local school administrative unit where the group or foster home is located an amount equal to the actual local cost in excess of the State and federal funding.

Bill Analysis.

The proposed committee substitute clarifies that:

- State and federal funds for the cost of a free appropriate public education for a child with disabilities in group and foster home are to be exhausted before the "home county" LEA is to reimburse the "host county" LEA.
- a local school administrative unit providing an education to a child with disabilities to submit an application for funds to the Special State Reserve Program when the costs exceed the per child group home allocation.

Additionally, the Department of Public Instruction is required to review the current costs to determine the actual local cost of services to children with disabilities. The proposed committee substitute would also change the description of 'child with special needs' to 'child with disabilities.'

Sections 2 and 4.

Current Law. G.S. 122-23 governs licensure for facilities for the mentally ill, the developmentally disabled and substance abusers. G.S. 131D-10.3 governs licensure for foster homes. With the intent to prevent a provider from gaining licensure or Medicaid provider status under one chapter after having lost licensure or provider status under the other chapter, both chapters were amended in 2002 to provide that licensure or enrollment for Medicaid was to be denied to any of the following person(s) within the stated time-frames:

- Someone who was the owner, principal, or affiliate of a licensable facility under Chapter 122C or Chapter 131D that had its license revoked until 60 months after the date of the revocation.
- Someone who is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a violation of client's rights until 60 months after the date of the violation.
- Someone who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

Someone who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapt 131D until 60 months after the date of reinstatement or restoration of the license.

Bill Analysis. The proposed committee substitute would make changes to the ability of the Secretary of Health and Human Services to issue licenses and enroll providers for Medicaid services. The changes would add child day care centers to those facilities that licensure discipline affects further licensure. Also the proposed committee substitute would amend the licensure statutes to provide that licensure or enrollment for Medicaid must be denied to someone who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license. The proposed committee substitute provides that licensure or new Medicaid enrollment is to be denied to:

(1) Someone who is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a client's rights violation and any one of the following conditions exist:
   a. A single violation has been assessed in the **six months** prior to the application.
   b. Two violations have been assessed in the 18 months prior to the application and **18 months** have not passed from the date of the most recent violation.
   c. Three violations have been assessed in the 36 months prior to the application and **36 months** have not passed from the date of the most recent violation.
   d. Four or more violations have been assessed in the 60 months prior to application and **60 months** have not passed from the date of the mos recent violation.

(2) Someone found by the Secretary to have a prior history as a provider under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that indicates the applicant will not be able to comply with licensing or enrollment statutes and rules promulgated under those statutes.

The sections also provide that the Secretary may issue a license or enroll a provider in the both of the following:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.
(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

Section 3. The proposed committee substitute would require licensure to be denied to an applicant for an adult care home who is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D or had its license summarily suspended or denied under Article 7 of Chapter 110 until **six months** from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

Section 5. The proposed committee substitute conforms language in S.L. 2002-164 to the current terminology used by the Department of Public Instruction. The proposed committee substitute would also clarify that the local school administrative unit requesting funding from the Group Homes Program for Children with Disabilities shall receive full school year funding.

Section 6.

- ***Current Law.*** The Department of Health and Human Services, in conjunction with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other affected agencies, shall report on the following Program information:
  - The number and other demographic information of children served.
  - The amount and source of funds expended to implement the Program.
  - Information regarding the number of children screened, specific placement of children including the placement of children in programs or facilities outside of the child's home county, and treatment needs of children served.
  - The average length of stay in residential treatment, transition, and return to home.
  - The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals and a description of the services provided.
  - Recommendations on other areas of the Program that need to be improved.
  - Other information relevant to successful implementation of the Program.
  - A method of identifying and tracking children placed outside of the family unit in group homes or therapeutic foster care home settings.

The proposed committee substitute would require the Department of Health and Human Services, together with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, to determine a method of identifying and ***reporting*** child placements outside the family unit group home and therapeutic foster care home settings. This is in addition to several other reporting requirements included in S.L. 2002-164 as stated above.

EFFECTIVE DATE: The proposed committee substitute would become effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 704

Short Title:	Traumatic Brain Injury Advisory Council.	(Public)
Sponsors:	Senator Kerr.	
Referred to:	Health & Human Resources.	

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 143B of the General Statutes is amended by adding the following new Part to read:

"Part 33. North Carolina Traumatic Brain Injury Advisory Council.

"**§ 143B-216.65. North Carolina Traumatic Brain Injury Advisory Council - creation and duties.**

(a) There is established the North Carolina Traumatic Brain Injury Advisory Council in the Department of Health and Human Services. The Council shall have duties including the following:

(1) Review how the term 'traumatic brain injury' is defined by the State and federal regulations and to determine whether changes should be made to the State definition to include 'acquired brain injury' or other appropriate conditions.

(2) Promote interagency coordination among State agencies responsible for services and support of individuals that have sustained traumatic brain injury.

(3) Study the needs of individuals with traumatic brain injury and their families.

(4) Make recommendations to the Governor, the General Assembly, and the Secretary of Health and Human Services regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.

(5) Promote and implement injury prevention strategies across the State.

"**§ 143B-216.66. North Carolina Traumatic Brain Injury Advisory Council - membership; quorum; compensation.**

(a) The Council shall consist of 25 members, appointed as follows:

(1) Two members by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:
  a. The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.
  b. A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.
(2) Two members by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:
  a. The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.
  b. A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.
(3) Nine members by the Governor, as follows:
  a. Three survivors of brain injury, one each representing the eastern, central, and western regions of the State.
  b. Three family members of persons with brain injury.
  c. A brain injury service provider in private practice.
  d. The director of an area program or county program of mental health, developmental disabilities, and substance abuse services.
  e. The Executive Director, or designee thereof, of the North Carolina Trial Lawyers Association.
(4) Eight members by the Secretary of Health and Human Services, one from each of the following:
  a. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
  b. The Division of Vocational Rehabilitation.
  c. The Council on Developmental Disabilities.
  d. The Division of Medical Assistance.
  e. The Division of Facility Services.
  f. The Division of Social Services.
  g. The Office of Emergency Medical Services.
  h. The Division of Public Health.
(5) Two by the Superintendent of Public Instruction, at least one of whom is from the Division of Exceptional Children.
(6) One by the Commissioner of Insurance.
(7) One by the Secretary of Administration representing veterans affairs.

(b) The terms of the initial members of the Council shall commence October 1, 2003. In his initial appointments, the Governor shall designate three members who shall serve terms of four years, three members who shall serve terms of three years, and three members who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member appointed by the Governor shall serve more than two successive terms.

Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

(c) The chair of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chair shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chair. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 704
PROPOSED COMMITTEE SUBSTITUTE S704-PCS65265-RP-5

Short Title: Traumatic Brain Injury Advisory Council. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 143B of the General Statutes is amended by adding the following new Part to read:

"Part 33. North Carolina Traumatic Brain Injury Advisory Council.

"**§ 143B-216.65. North Carolina Traumatic Brain Injury Advisory Council – creation and duties.**

There is established the North Carolina Traumatic Brain Injury Advisory Council in the Department of Health and Human Services. The Council shall have duties including the following:

(1) Review how the term 'traumatic brain injury' is defined by State and federal regulations and to determine whether changes should be made to the State definition to include 'acquired brain injury' or other appropriate conditions.

(2) Promote interagency coordination among State agencies responsible for services and support of individuals that have sustained traumatic brain injury.

(3) Study the needs of individuals with traumatic brain injury and their families.

(4) Make recommendations to the Governor, the General Assembly, and the Secretary of Health and Human Services regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.

(5) Promote and implement injury prevention strategies across the State.

"**§ 143B-216.66. North Carolina Traumatic Brain Injury Advisory Council – membership; quorum; compensation.**

(a) The Council shall consist of 25 members, appointed as follows:

(1) Two members by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:

a. The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.

b. A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.

(2) Two members by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:

a. The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.

b. A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.

(3) Nine members by the Governor, as follows:

a. Three survivors of brain injury, one each representing the eastern, central, and western regions of the State.

b. Three family members of persons with brain injury.

c. A brain injury service provider in private practice.

d. The director of an area program or county program of mental health, developmental disabilities, and substance abuse services.

e. The Executive Director, or designee thereof, of the North Carolina Trial Lawyers Association.

(4) Eight members by the Secretary of Health and Human Services, one from each of the following:

a. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

b. The Division of Vocational Rehabilitation.

c. The Council on Developmental Disabilities.

d. The Division of Medical Assistance.

e. The Division of Facility Services.

f. The Division of Social Services.

g. The Office of Emergency Medical Services.

h. The Division of Public Health.

(5) Two members by the Superintendent of Public Instruction, at least one of whom is from the Division of Exceptional Children.

(6) One member by the Commissioner of Insurance.

(7) One member by the Secretary of Administration representing veterans affairs.

(b) The terms of the initial members of the Council shall commence October 1, 2003. In his initial appointments, the Governor shall designate three members who shall serve terms of four years, three members who shall serve terms of three years, and three members who shall serve terms of two years. After the initial appointees' terms have

expired, all members shall be appointed for a term of four years. No member appointed by the Governor shall serve more than two successive terms.

Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

(c) The chair of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chair shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chair. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5 and G.S. 138-6, as applicable.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

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

SENATE BILL 704:
Traumatic Brain Injury Advisory Council

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Sen. Kerr
Date:	April 16, 2003	**Summary by:**	Amy Compeau
Version:	First Edition		Research Division Staff

SUMMARY: Senate Bill 704 would establish the Traumatic Brain Injury Advisory Council (Council) in the Department of Health and Human Services (DHHS). The Council would review definitions of traumatic brain injuries (TBI), promote interagency coordination, study the needs of individuals with TBI and their families, make recommendations on comprehensive statewide service delivery, and promote injury prevention. The act would become effective when it becomes law.

BILL ANALYSIS:

Duties of the Council

SB 704 would establish a Council within DHHS that would have the following duties:

1. Review definitions of "traumatic brain injury" as defined by State and federal regulations to determine whether changes should be made to the State definition.
2. Promote interagency coordination among State agencies responsible for services and support of individuals that have sustained TBI.
3. Study the needs of individuals with TBI and their families.
4. Make recommendations to the Governor, the General Assembly, and the Secretary of the Department of Health and Human Services (Secretary) regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.
5. Promote and implement injury prevention strategies across the State.

Council Membership

The Council would consist of 25 members as follows:

Number	Member Qualification
	(2) APPOINTEES OF THE PRESIDENT PRO TEMPORE
1	Executive Director of the Brain Injury Association of NC, or a designee
1	A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine
	(2) APPOINTEES OF THE SPEAKER
1	Chair of the Board of the Brain Injury Association of NC, or a designee
1	A physician, nurse, or other professional coordinator with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine
	(9) APPOINTEES OF THE GOVERNOR
3	Survivors of brain injury, from the eastern, central, and western regions of the State
3	Family members of persons with brain injury
1	A brain injury service provider in private practice
1	The director of an area program or county program of MH/DD/SA* services
1	The Executive Director of the NC Carolina Trial Lawyers Association, or a designee

	(8) APPOINTEES OF THE SECRETARY OF DHHS
1	Representative from the Division of MH/DD/SA* services
1	Representative from the Division of Vocational Rehabilitation
1	Representative from the Council on Developmental Disabilities
1	Representative from the Division of Medical Assistance
1	Representative from the Division of Facility Services
1	Representative from the Division of Social Services
1	Representative from the Office of Emergency Medical Services
1	Representative from the Division of Public Health
	(2) APPOINTEES OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION
2	At least one appointee shall be from the Division of Exceptional Children
	(1) APPOINTEE OF THE COMMISSIONER INSURANCE
1	N/A
	(1) APPOINTEE OF THE SECRETARY OF ADMINISTRATION
1	Appointee represents veterans affairs
25	**Total Members**

* MH/DD/SA stands for Mental Health, Developmental Disabilities, and Substance Abuse.

Council Terms and Structure

TERMS: The terms of the initial members of the Council would commence October 1, 2003. The Governor's initial 9 appointees would have staggered terms. After the initial appointees' terms expire, all members would be appointed for 4-year terms. No member appointed by the Governor would serve more than 2 successive terms.

STRUCTURE: The chair of the Council would be designated by the Secretary and would not hold the office for more than four years. The Council would meet quarterly and at other times at the call of the chair. A majority of the Council would constitute a quorum. FUNDS: Members would be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5 and G.S. 138-6, as applicable. In addition, the Secretary would provide clerical and other assistance as needed.

BACKGROUND: The Health Resources and Services Administration (HRSA) recommends that each state create, through statute, a TBI Advisory Council. According to HRSA, 20 states have established such Councils.

The below data was compiled by staff from the Division of MH/DD/SA services, DHHS.

National Statistics

A TBI may be classified as severe, moderate or mild. National estimates from the Centers for Disease Control and Prevention (CDC) suggest there are as many as 1.5 million persons with mild to severe TBI per year in the U.S. Putting this in perspective of other well-known chronic diseases, TBI occurs 8 times more often than the number of people diagnosed with breast cancer and 34 times the number of new cases of HIV/AIDS. CDC estimates that annually approximately 230,000 people with TBI are hospitalized and survived; over 1 million are treated in an Emergency Department.

State Statistics

The injury surveillance systems in the State for TBI can only identify the most severe cases of TBI, i.e., the number of residents who died or were hospitalized from a brain injury. The NC State Center for Health Statistics reports that in 2001, 1,800 State residents died from TBI (a rate of 22.1 per 100,000 population). Also in 2001, there were 4,600 TBI hospitalizations (a rate of 56.4 per 100,000 population). The highest *number* of TBI deaths and hospitalizations occur to adolescents and young adults, primarily from motor vehicle crashes (MVC) and firearms in homicides and suicides. In contrast, the highest *rates* of TBI deaths and hospitalizations occur in people age 85 and older, primarily as the consequences of falls. According to the NC Medical Journal, the risk for TBI, overall, is twice as great in men than women.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 724

Short Title:	Discharge from Adult Care Homes.	(Public)
Sponsors:	Senators Kinnaird; Dannelly, Dorsett, Garrou, Gulley, Lucas, Malone, Metcalf, and Reeves.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE CIRCUMSTANCES UNDER WHICH A RESIDENT MAY BE TRANSFERRED OR DISCHARGED FROM AN ADULT CARE HOME.

The General Assembly of North Carolina enacts:

SECTION 1. 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 following circumstances shall not create a presumption of jeopardy to health or safety:

a. The resident's welfare is affected because the resident's needs cannot be met by the facility.

b. The physician has authorized a change to a higher level of care for the resident.

c. The facility determines that the resident's health needs cannot be met in the facility.

In any of the circumstances listed in subparagraphs a. through c. of this subdivision, unless there is jeopardy to health or safety and an emergency requiring an immediate transfer or discharge, then prior to the 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 assessment shall include a description of the problem purported to justify transfer or discharge, a description of the interventions attempted to address the problem, and a description of the results of the intervention. At least three working days prior to providing the assessment or other information to the physician to support a request for a change in the resident's level of care, the facility must provide the same information to the resident and the resident's legal representative along with notice to the recipients that the information will be provided to the physician and that this could affect the person's level of care and continuing stay in the facility. For residents who are recipients of medical assistance, a level of care change recorded on the level of care authorization form signed by the physician (FL-2 form) is not effective to support a transfer or discharge based on a need for a higher level of care until a prior approval number has been assigned.

The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the 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 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 2. This act becomes effective July 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 724
PROPOSED COMMITTEE SUBSTITUTE S724-CSRP-4 [v.4]

4/16/2003 10:12:46 AM

Short Title: Discharge from Adult Care Homes. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE CIRCUMSTANCES UNDER WHICH A RESIDENT MAY BE TRANSFERRED OR DISCHARGED FROM AN ADULT CARE HOME.

The General Assembly of North Carolina enacts:

SECTION 1. 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 imminent jeopardy to the health or safety of the resident or others in the home. The following circumstances shall not create a presumption of imminent jeopardy to health or safety:

a. The resident's welfare is affected because the resident's needs cannot be met by the facility.

b. The physician has authorized a change to a higher level of care for the resident.

c. The facility determines that the resident's health needs cannot be met in the facility.

For any transfer or discharge other than for nonpayment or because of imminent jeopardy to health or safety that precludes undertaking an assessment in the manner described below, notwithstanding G.S.

131D-2(a1)(4), prior to the 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 so that a transfer or discharge would not be necessary. The assessment shall include a description of the problem purported to justify transfer or discharge, a description of the interventions attempted to address the problem, and a description of the results of the intervention. At least three working days prior to providing the assessment or other information to the physician to support a request for a change in the resident's level of care, the facility shall provide the same information to the resident and the resident's legal representative along with notice to the recipients that the information will be provided to the physician and that this could affect the resident's level of care and continuing stay in the facility. For residents who are recipients of medical assistance, a level of care change recorded on the level of care authorization form signed by the physician (FL-2 form) shall not be effective to support a transfer or discharge based on a need for a higher level of care until a fiscal agent in the Division of Medical Assistance has determined that the recipient meets the criteria for nursing facility level of care.

The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the 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 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 2. This act becomes effective July 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 388
PROPOSED COMMITTEE SUBSTITUTE S388-PCS85220-RM-13

Short Title: Update Cervical Cancer Screening Coverage. (Public)

Sponsors:

Referred to:

March 12, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

The General Assembly of North Carolina enacts:

SECTION 1. 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 all of the following:

(1) Mammograms and ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer 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) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are 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. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

(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."

SECTION 2. G.S. 58-51-57 reads as rewritten:

"**§ 58-51-57. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 58-65-92 reads as rewritten:

"**§ 58-65-92. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an

~~standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 5.(a) 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 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~~ examinations and tests for the screening for the early detection of cervical cancer. The coverage shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for any covered female. For the purposes of this subsection, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis. 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 5.(b) G.S. 135-40.6(8)s. reads as rewritten:

...

s. Routine Diagnostic Examinations: Allowable charges for routine diagnostic examinations and tests, including ~~Pap smears,~~ examinations and tests for the screening for the early detection of cervical cancer, 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, and, for examinations and tests for the screening for the early detection of cervical cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. 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. For purposes of this subdivision, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

..."

SECTION 6. This act becomes effective January 1, 2004, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit 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.

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES — **Name of Committee**

APRIL 16, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Murphy	DPI
Gene Causby	NCSBA
Cora Harrison	Self-employed
Paul Harrison	
Harry Kaplan	
Sarah Toney	Sen. Kerr
Barbara Brooks	Division of Medical Assistance | DHHS
Sharron Leinward	DMA / DHHS
Odell Lyndell	Rem Life TBI
Kacky C. Hammon	Brain Injury Association of NC
James Harrison	ReMe Lifes Extended, Goldsboro NC

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES — **APRIL 16, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tonia Harrison	TBI Survivor
Peggy Philbrick	BIANC/CIR 19929 OAK LEAF CR. CORNELIUS, NC 28031
Ilse Nofziger	BI Parent + Caregiver same
Lowell Nofziger	BI Parent + Caregiver
Chad Essick	Edmisten + Webb
DAN WHITLEY	CWA 3611
Drew Edwards	CWA 3611
Doris Weaver	NC CWA Political Council
Susan M Snow	"
Phil Telfer	Gov. Office
Vandana Shah	Health & Wellness Trust Fund

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES — **APRIL 16, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Morales Burke	NC Dept. of Insurance
Jim Upchurch	DHHS/DFS
Gary Barnett	DHHS/DFS
Michael Massey	Brain Injury Assoc of NC 4110 Chapin Glen Dr. Durham
Linda Olive Smith	Linking Services for Persons w/ BI PO Box 369, Fairmont, NC 28340
Marilyn Lash	708 Young Forest Dr. Wake Forest 27587 Brain Injury Assoc. NC
Charles "Chuck" Heaton	Spokesperson for Brain Injury Assoc. 420 Goldsboro, NC 27534
Chris Nichols	Heaton + Williams
Stephen M. Farrar	Hemophilia of NC
Cheryl Hoots	Hemophilia of NC
Matthew Igelman	Hemophilia of NC
Lou Wilson	NC ALTCF
Roger Bone	Bone & Assoc

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES — **APRIL 16, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judy Igelman	Hemophilia of NC Inc Winston-Salem, NC
Jerry Cooper	NCALA
Evelyn Hawthorne	EHGR
Butch Gunnells	NCSDA
Susan Harrison	WCPSS
Marshall McConnell	Carolinas Healthcare Sys.
Stacy Flannery	NCHCFA
Elizabeth Dalton	Bone & Assoc.
[illegible]	NCICU
[illegible]	N.C.S.D.A.
[illegible]	NCSDA
[illegible]	NCSDA

VISITOR REGISTRATION SHEET

HEALTH AND HUMAN RESOURCES — **APRIL 16, 2003**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael A. Mayer	NCCSPC
Janet Schanzenbach	NC Council
Jim Blackburn	NC Association of County Commissioners
Scott Sorenson	Hemophilia Health Services
Stephen Tanner	Hemophilia of N.C.
Beverly P. Wheeler	Friends of Residents
Roger Nunnes	" " "
Melvl. Whitley	Career Nursing Assistant Network

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Thursday, April 17, 2003 at 8:00 A.M.
Room 414, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- SB 876, *Meningitis Immunization*
- SB 880, *UNC/Add Nonsmoking Area*
- SB 897, *Medicaid Prior Authorization*
- SB 388, *Update Cervical Cancer Screening Coverage*
- SB 648, *Cervical Cancer Elimination Task Force*

III. Other Business

IV. Adjournment

REVISED

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
SENATE
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Monday, April 21, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **648** Cervical Cancer Elimination Task Force.

Draft Number:	PCS40019
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

S.B. **704** Traumatic Brain Injury Advisory Council.

Draft Number:	PCS65265
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **876** Meningitis Immunization.

Draft Number:	PCS75241
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **897** Medicaid Prior Authorization.

Draft Number:	PCS85214
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **926** Clarify Group Homes Licensure & LEA reimburs.

Draft Number:	PCS65264
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 5

Committee Clerk Comments:

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Thursday, April 17, 2003
8:00 A.M.
Room 414, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 8:00 A.M. on Thursday, April 17, 2003, in Room 414 of the Legislative Office Building. Ten members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Bingham, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Purcell recognized Senator Queen to present his bill, SB 897, *Medicaid Prior Authorization.* Senator Hartsell moved to accept the proposed committee substitute for discussion purposes. The motion passed. Senator Queen asked Mr. Steve Farrell, President of the Hemophilia Association to speak on the bill. Senator Dannelly moved for a favorable report for the proposed committee substitute, unfavorable as to the original bill; the motion was seconded and passed.

Senator Apodaca was called on to explain his bill, SB 880, to the committee. Mr. Mark Fleming of the North Carolina University System spoke in favor of the bill. After a short discussion Senator Dannelly moved for a favorable report. The motion passed.

Senator Purcell called on Senator Foxx to present her bill, SB 648, *Cervical Cancer Elimination Task Force.* Senator Dannelly moved that the proposed committee substitute be adopted for purposes of discussion. Senator Foxx outlined the history of the bill. Senator Kinnaird moved for a favorable report for the proposed committee substitute, unfavorable as to the original bill. The motion passed. The bill was sequentially referred to the Appropriations Committee.

Senator Foxx described her bill, SB 388, *Update Cervical Cancer Screening Coverage.* Senator Dannelly moved that the proposed committee substitute be adopted for purposes of discussion. Senator Purcell said that this bill needs an actuarial note and therefore cannot be voted on at this meeting, but welcomed discussion.

Senator Allran presided for Senator Purcell while Senator Purcell presented his bill, SB 876, *Meningitis Immunization.* Senator Dannelly moved to adopt the proposed committee substitute for purposes of discussion; the motion passed. Senator Purcell asked Mr. Paul Harrison, who had lost a daughter to meningitis, to speak on the bill. Senator Hartsell asked if there were any risks to the vaccine. Senator Purcell said there was very little risk, if any. Senator Dannelly moved for a favorable report for the proposed committee substitutes, unfavorable as to the original bill. The motion passed.

The meeting adjourned at 8:46 A.M.

William R. Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 897

Short Title:	Medicaid Prior Authorization.	(Public)
Sponsors:	Senator Queen.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT FROM PRIOR AUTHORIZATION REQUIREMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAID PROGRAM ANTIHEMOPHILIC DRUGS PRESCRIBED FOR THE TREATMENT OF HEMOPHILIA AND BLOOD DISORDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-68.1. Certain prescription drugs exempt from prior authorization requirements.**

Prior authorization shall not be required or utilized for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available. This section applies to any supplemental drug rebate program established or administered by the Department."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 897
PROPOSED COMMITTEE SUBSTITUTE S897-CSSW-17 [v.3]

4/16/2003 10:44:27 AM

Short Title: Medicaid Prior Authorization. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO EXEMPT FROM PRIOR AUTHORIZATION REQUIREMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAID PROGRAM ANTIHEMOPHILIC DRUGS PRESCRIBED FOR THE TREATMENT OF HEMOPHILIA AND BLOOD DISORDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-68.1. Certain prescription drugs exempt from prior authorization requirements.**

Prior authorization shall not be required or utilized for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available. Nothing in this section shall prohibit the Secretary from implementing a disease management program."

SECTION 2. This act is effective when it becomes law and expires July 1, 2006.

SENATE BILL 897:
Medicaid Prior Authorization

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Sen. Queen
		Summary by:	Dianna Jessup Committee Counsel
Date:	April 16, 2003		
Version:	First Edition		

SUMMARY: ***Senate Bill 897 would exempt prescription drugs for hemophilia and blood disorders from prior authorization requirements under Medicaid where there is no generically equivalent drug available. The act would become effective when it becomes law.***

CURRENT LAW: According to the Division of Medical Assistance, Department of Health and Human Services, during fiscal year 2002, the Medicaid program spent $1,056,158,750 on outpatient pharmacy benefits for Medicaid recipients, a 13.9% increase from the previous fiscal year. The pharmacy benefit is one of the most costly components of the Medicaid budget. To help control costs, prescribers are required to obtain prior authorization for certain designated drugs. The list of these drugs is not in statute, but is maintained by DMA and communicated to providers. Currently, prior authorization is required for the following prescription drugs:

Medicaid Prior Authorization List

- Drugs used to treat ADHD
- Procrit/Epogen
- Neopogen
- OxyContin
- Growth Hormones
- Provigil
- Rebetron
- Vioxx, Celebrex, Bextra
- Enbrel, Betaseron, Copaxone
- Botox, Myobloc, Zyban, Nicotrol, Habitrol
- Synagis, RespiGam

Generally, these drugs were chosen because of their high cost or because of the potential for overutilizaton or abuse. Prior approval is administered by ACS (Affiliated Computer Systems) in Atlanta. The prescriber contacts ACS directly for prior approval by telephone, fax, email, or mail. Prior approval requests are generally processed within 24 hours.

Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can call ACS for approval. If it is after ACS hours, the pharmacist can dispense a 72-hour supply.

Supplemental drug rebate programs: In a supplemental drug rebate program, drug manufacturers pay a rebate to a state in order to be included on a preferred drug list. For the current fiscal year, pursuant to a

special provision in the budget, the Secretary of the Department of Health and Human Services is prohibited from requiring supplemental rebates from manufacturers.

Blood disorders and hemophilia: Bleeding disorders, characterized by a tendency to bleed easily, may result from defects in the blood vessels or from abnormalities in the blood itself. The abnormalities may be in the blood clotting factors or the platelets. Hemophilia is an inherited bleeding disorder that affects 18,000 persons (primarily males) in the United States. The disorder results from deficiencies in blood clotting factors and can lead to spontaneous internal bleeding and bleeding following injuries or surgery. Antihemophilic factor drugs are used to help the blood form clots and are administered by IV or injection. Currently, there are no generic equivalents for these drugs.

BILL ANALYSIS: If Senate Bill 897 were enacted, prior authorization could not be required or utilized for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available. This would be the only class of drugs exempt from prior authorization by statute. This exemption would also apply to any supplemental drug rebate program established or administered by the Department, if and when the General Assembly permits a supplemental drug rebate program.

S897-SMSW-001

Hemophilia of North Carolina
1705 Link Road
Winston - Salem, NC 27103
336-725-4872
800-990-5557
Fax 336-725-4873
hofnorth@bellsouth.net

April 14, 2003

Mr. Chairman and Members of the Senate Health and Human Resources Committee. My name is Stephen Farrar I am the president of Hemophilia of North Carolina (HNC) and we represent the interest of people with bleeding disorders in North Carolina. I am here today to talk to you about access to antihemophilic clotting factor. We here at HNC are greatly concerned with limiting choice of clotting products to the bleeding disorders community in North Carolina. It is of the utmost importance that persons with bleeding disorders be allowed to use the safest products available.

Our community is very leery of limiting it's choice especially after the late seventies and early eighties, when so many people with bleeding disorders contracted HIV/Aids through contaminated blood products. The whole reason for developing recombinant products was to get a safer more purified product that would greatly reduce the chance of viral transmission. **We believe that the choice of product is best left up to the individual and their physician.** There are many factors that go into determining which product is best, such as inhibitors or other medical complications that would prohibit the use of certain products. Bleeding disorders are a complex condition and a lot of factors got into treating a person with a bleeding disorder.

We are very aware of the state's budget crisis and the need to find creative solutions to control cost. **We believe that limiting choice of product that a person with a bleeding disorder has, could actually lead to great cost in the near future for the Medicaid program by the potential complications of a blood born viral infection that the current purification process can not eliminate.**

The other concern is with preauthorization of clotting factor, any delay in getting product to someone with a bleeding disorder could have devastating consequences. Delay in getting product could cause a minor bleed to become a major one in no time. **A person with a bleeding disorder waiting on authorization to get his or her product may have to go to the emergency room which would lead to greater cost and probably would have to deal with medical personal who are not familiar how to treat a person with a bleeding disorder and by the time they figure it out the pharmacy most likely would not have product on hand , leading to more delay with a good chance of joint damage occurring or leading to a life threatening situation.**

We believe that is in the best interest to exempt antihemophilic products form any limitations as choice of product or preauthorization. Thank you allowing me to bring the concerns of the bleeding disorders community to you.

Respectfully
Stephen Farrar
President of Hemophilia of North Carolina

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 880

Short Title:	UNC/Add Nonsmoking Areas.	(Public)
Sponsors:	Senator Apodaca.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO ADD PARTICULAR UNIVERSITY FACILITIES AS NONSMOKING AREAS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-597(a) reads as rewritten:

"(a) All of the following areas may be designated as nonsmoking in buildings owned, leased, or occupied by State government:

(1) Any library open to the public.

(2) Any museum open to the public.

(3) Any area established as a nonsmoking area, so long as at least twenty percent (20%) of the interior space of equal quality to that of the nonsmoking area shall be designated as a smoking area, unless physically impracticable. If physically impracticable, the person in charge of the facility shall provide an adequate smoking area within the facility as near as feasible to twenty percent (20%) of the interior space.

(4) Any indoor space in a State-controlled building such as an auditorium, arena, or coliseum, or an appurtenant building thereof; except that a designated area for smoking shall be established in lobby areas.

(5) Any educational buildings primarily involved in health care instruction.

(6) University of North Carolina health services facilities, wellness centers, physical education facilities, student recreational centers, laboratories, or residence halls, provided that not all residence halls within a constituent institution may be designated nonsmoking."

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

SENATE BILL 880:
UNC/Add Nonsmoking Areas.

BILL ANALYSIS

Committee:	Senate Health and Human Services	**Introduced by:**	Sen. Apodaca
Date:	April 16, 2003	**Summary by:**	Sara Kamprath Committee Analyst
Version:	First Edition		

BILL ANALYSIS: Senate Bill 880 adds the following University of North Carolina areas to the list of those areas that may be designated as nonsmoking in buildings owned, leased, or occupied by State government: health services facilities, wellness centers, physical education facilities, student recreational centers, labs, or residence halls, provided that not all residence halls at a constituent institution may be designated as nonsmoking. The act is effective when it becomes law.

S880-SMRJ-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 648

Short Title:	Cervical Cancer Elimination Task Force.	(Public)
Sponsors:	Senators Foxx; Apodaca, Blake, Brock, Carpenter, Dorsett, Forrester, Garrou, Hagan, Hoyle, Kerr, Kinnaird, Lucas, Pittenger, Purcell, Reeves, Shubert, and Tillman.	
Referred to:	Health & Human Resources.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN AD HOC CERVICAL CANCER ELIMINATION TASK FORCE TO THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL.

The General Assembly of North Carolina enacts:

SECTION 1.(a) A standing ad hoc task force on cervical cancer elimination is established pursuant to this act to serve the Advisory Committee on Cancer Coordination and Control. The ad hoc task force shall be called the Cervical Cancer Elimination Task Force (Task Force). The task force shall perform the duties specified in subsection (j) of this section.

SECTION 1.(b) The Task Force shall have 23 members. The Governor shall appoint the Chair. The Task Force shall elect the Vice-Chair. The Director of the Division of Public Health in the Department of Health and Human Services, the Director of the Division of Medical Assistance in the Department of Health and Human Services, the Chair and Vice-Chair of the North Carolina's Legislative Women's Caucus, or their designees, shall be members of the Task Force. The Task Force shall elect the Vice-Chair. The following additional members shall be appointed as follows:

(1) By the President Pro Tempore of the Senate, as follows:
   a. One member of the Senate;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;
   c. A representative of a women's health organization;
   d. A representative from the American Academy of Pediatrics; and
   e. A certified schoolteacher.

(2) By the Speaker(s) of the House of Representatives:
   a. One member of the House;

b. Two representatives from the North Carolina's Legislative Women's Caucus;
c. A member of the North Carolina Cancer Society;
d. A member of the health insurance industry; and
e. A member from the American College of Obstetrics and Gynecology.

(3) By the Governor, as follows:
a. A member of the American Academy of Family Physicians;
b. The State Epidemiologist;
c. Two members at large;
d. A news director of a newspaper or television or radio station; and
e. A licensed registered nurse.

SECTION 1.(c) Each appointing authority shall assure, insofar as possible, that its appointees to the Task Force reflect the composition of the North Carolina population with regard to ethnic, racial, age, and religious composition.

SECTION 1.(d) The General Assembly and the Governor shall make their appointments to the Task Force not later than 30 days after the adjournment of the 2003 Regular Session of the General Assembly. The original appointing authority, using the criteria set out in this section for the original appointment shall fill a vacancy on the Task Force.

SECTION 1.(e) The Task Force shall meet at least quarterly or more frequently at the call of the Chair.

SECTION 1.(f) The Task Force Chair may establish committees for the purpose of making special studies pursuant to its duties and may appoint non-Task Force members to serve on each committee as resource persons. Resource persons shall be voting members of the committees and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. Committees may meet with the frequency needed to accomplish the purposes of this section.

SECTION 1.(g) Members of the Task Force shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 120-3.1, 138-5, and 138-6, as applicable.

SECTION 1.(h) A majority of the Task Force shall constitute a quorum for the transaction of its business.

SECTION 1.(i) The Task Force may use funds allocated to it, by the legislature, to establish one fulltime position and for other expenditures needed to assist the Task Force in carrying out its duties.

SECTION 1.(j) The Task Force shall have the following duties:

(1) To undertake a statistical and qualitative examination of the prevalence and burden of cervical cancer.

(2) To raise public awareness on the causes and nature of cervical cancer, personal risk factors, value of prevention, early detection, options for testing, treatment costs, new technology, medical care reimbursement, and physician education.

(3) To identify priority strategies, new technologies or newly introduced vaccines which are effective in preventing and controlling the risk of cervical cancer.

(4) To identify and examine the limitations of existing laws, regulations, programs, services with regard to coverage and awareness issues for cervical cancer, including amending G.S. 58-51-57 to require every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued or renewed, or amended on or after January 1, 2004, to provide coverage for PAP smears and mammograms in accordance with the most recently published American Cancer Society Guidelines.

(5) To develop a statewide comprehensive Cervical Cancer Prevention Plan, and strategies for Plan implementation and for promoting the Plan to the general public, State and local elected officials, various public and private organizations and associations, businesses, industries and agencies.

(6) To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (8) of this subsection.

(7) To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Cervical Cancer Task Force Plan.

(8) To receive and to consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide, to learn more about their contributions to cervical cancer diagnosis, prevention and treatment, and more about their ideas for improving cervical cancer prevention, diagnosis, and treatment in North Carolina.

SECTION 1.(k) The Task Force shall submit an annual report to the Advisory Committee on Cancer Coordination and Control beginning in 2004. The report shall also be presented to the North Carolina 's Legislative Women's Caucus, the Governor, and the Joint Legislative Commission on Governmental Operations not later than April 1, 2004. The annual report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Cervical Cancer Plan.

(2) The anticipated time frame for completion of the Prevention Plan.

(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from cervical cancer by citizens of the State.

SECTION 1.(l) Upon submission of the Task Force's final report to the Advisory Committee on Cancer Coordination and Control, to the Governor and the 2008 Regular Session of the 2007 General Assembly, the Task Force shall expire.

SECTION 2. The Department of Health and Human Services, Division of Public Health, shall use funds appropriated to it for the 2003-2004 fiscal year to implement this act.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 648
PROPOSED COMMITTEE SUBSTITUTE S648-PCS40019-SW-16

Short Title: Cervical Cancer Elimination Task Force. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN AD HOC CERVICAL CANCER ELIMINATION TASK FORCE TO THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL.

The General Assembly of North Carolina enacts:

SECTION 1.(a) A standing ad hoc task force on cervical cancer elimination is established pursuant to this act to serve the Advisory Committee on Cancer Coordination and Control. The ad hoc task force shall be called the Cervical Cancer Elimination Task Force (Task Force). The task force shall perform the duties specified in subsection (j) of this section.

SECTION 1.(b) The Task Force shall have 22 members. The Director of the Division of Public Health in the Department of Health and Human Services, the Director of the Division of Medical Assistance in the Department of Health and Human Services, the Chair and Vice-Chair of the North Carolina's Legislative Women's Caucus, or their designees, shall be members of the Task Force. The following additional members shall be appointed as follows:

(1) By the President Pro Tempore of the Senate, as follows:
   a. One member of the Senate;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;
   c. A representative of a women's health organization;
   d. A representative from the American Academy of Pediatrics; and
   e. A certified schoolteacher.

(2) By the Speaker(s) of the House of Representatives:
   a. One member of the House;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;

c. A member of the North Carolina Cancer Society;
d. A member of the health insurance industry; and
e. A member from the American College of Obstetrics and Gynecology.

(3) By the Governor, as follows:
a. A member of the American Academy of Family Physicians;
b. The State Epidemiologist;
c. Two members at large;
d. A news director of a newspaper or television or radio station; and
e. A licensed registered nurse.

The Governor shall choose a Chair from among the members of the Task Force. The Task Force shall elect a Vice-Chair from its members.

SECTION 1.(c) Each appointing authority shall assure, insofar as possible, that its appointees to the Task Force reflect the composition of the North Carolina population with regard to ethnic, racial, age, and religious composition.

SECTION 1.(d) The General Assembly and the Governor shall make their appointments to the Task Force not later than 30 days after the adjournment of the 2003 Regular Session of the 2003 General Assembly. The original appointing authority, using the criteria set out in this section for the original appointment, shall fill a vacancy on the Task Force.

SECTION 1.(e) The Task Force shall meet at least quarterly or more frequently at the call of the Chair.

SECTION 1.(f) The Task Force Chair may establish committees for the purpose of making special studies pursuant to its duties and may appoint non-Task Force members to serve on each committee as resource persons. Resource persons shall be voting members of the committees and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. Committees may meet with the frequency needed to accomplish the purposes of this section.

SECTION 1.(g) Members of the Task Force shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 120-3.1, 138-5, and 138-6, as applicable.

SECTION 1.(h) A majority of the Task Force shall constitute a quorum for the transaction of its business.

SECTION 1.(i) The Task Force may use funds allocated to it, by the legislature, to establish one full-time position and for other expenditures needed to assist the Task Force in carrying out its duties.

SECTION 1.(j) The Task Force shall have the following duties:

(1) To undertake a statistical and qualitative examination of the prevalence and burden of cervical cancer.

(2) To raise public awareness on the causes and nature of cervical cancer, personal risk factors, value of prevention, early detection, options for testing, treatment costs, new technology, medical care reimbursement, and physician education.

(3) To identify priority strategies, new technologies or newly introduced vaccines which are effective in preventing and controlling the risk of cervical cancer.

(4) To identify and examine the limitations of existing laws, regulations, programs, services with regard to coverage and awareness issues for cervical cancer, including amending G.S. 58-51-57 to require every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued or renewed, or amended on or after January 1, 2004, to provide coverage for PAP smears and mammograms in accordance with the most recently published American Cancer Society Guidelines.

(5) To develop a statewide comprehensive Cervical Cancer Prevention Plan, and strategies for Plan implementation and for promoting the Plan to the general public, State and local elected officials, various public and private organizations and associations, businesses, industries, and agencies.

(6) To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (8) of this subsection.

(7) To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Cervical Cancer Task Force Plan.

(8) To receive and to consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide, to learn more about their contributions to cervical cancer diagnosis, prevention, and treatment, and more about their ideas for improving cervical cancer prevention, diagnosis, and treatment in North Carolina.

SECTION 1.(k) Beginning April 1, 2004, and on April 1 each year thereafter, the Task Force shall submit a report to the Advisory Committee on Cancer Coordination and Control. At the time the Task Force submits its report to the Advisory Committee, the Task Force shall also present its report to the North Carolina's Legislative Women's Caucus, the Governor, and the Joint Legislative Commission on Governmental Operations. Each annual report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Cervical Cancer Plan.

(2) The anticipated time frame for completion of the Prevention Plan.

(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from cervical cancer by citizens of the State.

SECTION 1.(l) Upon submission of the Task Force's final report to the Advisory Committee on Cancer Coordination and Control, to the Governor, and to the 2008 Regular Session of the 2007 General Assembly, the Task Force shall expire.

SECTION 2. The Department of Health and Human Services, Division of Public Health, shall use funds appropriated to it for the 2003-2004 fiscal year to implement this act.

SECTION 3. This act becomes effective July 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 648
PROPOSED COMMITTEE SUBSTITUTE S648-CSSW-16 [v.1]

4/16/2003 9:44:13 AM

Short Title: Cervical Cancer Elimination Task Force. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN AD HOC CERVICAL CANCER ELIMINATION TASK FORCE TO THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL.

The General Assembly of North Carolina enacts:

SECTION 1.(a) A standing ad hoc task force on cervical cancer elimination is established pursuant to this act to serve the Advisory Committee on Cancer Coordination and Control. The ad hoc task force shall be called the Cervical Cancer Elimination Task Force (Task Force). The task force shall perform the duties specified in subsection (j) of this section.

SECTION 1.(b) The Task Force shall have 22 members. The Director of the Division of Public Health in the Department of Health and Human Services, the Director of the Division of Medical Assistance in the Department of Health and Human Services, the Chair and Vice-Chair of the North Carolina's Legislative Women's Caucus, or their designees, shall be members of the Task Force. The following additional members shall be appointed as follows:

(1) By the President Pro Tempore of the Senate, as follows:
   a. One member of the Senate;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;
   c. A representative of a women's health organization;
   d. A representative from the American Academy of Pediatrics; and
   e. A certified schoolteacher.

(2) By the Speaker(s) of the House of Representatives:
   a. One member of the House;
   b. Two representatives from the North Carolina's Legislative Women's Caucus;

c. A member of the North Carolina Cancer Society;
d. A member of the health insurance industry; and
e. A member from the American College of Obstetrics and Gynecology.

(3) By the Governor, as follows:
a. A member of the American Academy of Family Physicians;
b. The State Epidemiologist;
c. Two members at large;
d. A news director of a newspaper or television or radio station; and
e. A licensed registered nurse.

The Governor shall choose a chair from among the members of the Task Force. The Task Force shall elect a Vice-Chair from its members.

SECTION 1.(c) Each appointing authority shall assure, insofar as possible, that its appointees to the Task Force reflect the composition of the North Carolina population with regard to ethnic, racial, age, and religious composition.

SECTION 1.(d) The General Assembly and the Governor shall make their appointments to the Task Force not later than 30 days after the adjournment of the 2003 Regular Session of the 2003 General Assembly. The original appointing authority, using the criteria set out in this section for the original appointment shall fill a vacancy on the Task Force.

SECTION 1.(e) The Task Force shall meet at least quarterly or more frequently at the call of the Chair.

SECTION 1.(f) The Task Force Chair may establish committees for the purpose of making special studies pursuant to its duties and may appoint non-Task Force members to serve on each committee as resource persons. Resource persons shall be voting members of the committees and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. Committees may meet with the frequency needed to accomplish the purposes of this section.

SECTION 1.(g) Members of the Task Force shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 120-3.1, 138-5, and 138-6, as applicable.

SECTION 1.(h) A majority of the Task Force shall constitute a quorum for the transaction of its business.

SECTION 1.(i) The Task Force may use funds allocated to it, by the legislature, to establish one fulltime position and for other expenditures needed to assist the Task Force in carrying out its duties.

SECTION 1.(j) The Task Force shall have the following duties:

(1) To undertake a statistical and qualitative examination of the prevalence and burden of cervical cancer.

(2) To raise public awareness on the causes and nature of cervical cancer, personal risk factors, value of prevention, early detection, options for testing, treatment costs, new technology, medical care reimbursement, and physician education.

(3) To identify priority strategies, new technologies or newly introduced vaccines which are effective in preventing and controlling the risk of cervical cancer.

(4) To identify and examine the limitations of existing laws, regulations, programs, services with regard to coverage and awareness issues for cervical cancer, including amending G.S. 58-51-57 to require every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued or renewed, or amended on or after January 1, 2004, to provide coverage for PAP smears and mammograms in accordance with the most recently published American Cancer Society Guidelines.

(5) To develop a statewide comprehensive Cervical Cancer Prevention Plan, and strategies for Plan implementation and for promoting the Plan to the general public, State and local elected officials, various public and private organizations and associations, businesses, industries and agencies.

(6) To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (8) of this subsection.

(7) To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Cervical Cancer Task Force Plan.

(8) To receive and to consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide, to learn more about their contributions to cervical cancer diagnosis, prevention and treatment, and more about their ideas for improving cervical cancer prevention, diagnosis, and treatment in North Carolina.

SECTION 1.(k) Beginning April 1, 2004, and on April 1 each year thereafter, the Task Force shall submit a report to the Advisory Committee on Cancer Coordination and Control. At the time the Task Force submits its report to the Advisory Committee, the Task Force shall also present its report to the North Carolina 's Legislative Women's Caucus, the Governor, and the Joint Legislative Commission on Governmental Operations. Each annual report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Cervical Cancer Plan.

(2) The anticipated time frame for completion of the Prevention Plan.

(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from cervical cancer by citizens of the State.

SECTION 1.(l) Upon submission of the Task Force's final report to the Advisory Committee on Cancer Coordination and Control, to the Governor and the 2008 Regular Session of the 2007 General Assembly, the Task Force shall expire.

SECTION 2. The Department of Health and Human Services, Division of Public Health, shall use funds appropriated to it for the 2003-2004 fiscal year to implement this act.

SECTION 3. This act becomes effective July 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 388

Short Title:	Update Cervical Cancer Screening Coverage.	(Public)
Sponsors:	Senators Foxx; Allran, Apodaca, Bingham, Blake, Brock, Carpenter, Carrington, Dorsett, Forrester, Garrou, Garwood, Gulley, Hagan, Hargett, Hartsell, Horton, Jenkins, Kerr, Kinnaird, Lucas, Queen, Shubert, Sloan, Stevens, Swindell, Thomas, Tillman, and Weinstein.	
Referred to:	Health and Human Resources.	

March 12, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

The General Assembly of North Carolina enacts:

SECTION 1. 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 all of the following:

(1) Mammograms and ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer 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) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are 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. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The

same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

(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."

SECTION 2. G.S. 58-51-57 reads as rewritten:

"**§ 58-51-57. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets

mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 58-65-92 reads as rewritten:

"**§ 58-65-92. Coverage for mammograms and ~~pap smears~~ cervical cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;
b. The woman has a personal history of biopsy-proven benign breast disease;
c. The woman's mother, sister, or daughter has or has had breast cancer; or
d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission. ~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 59-67-76 reads as rewritten:

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is determined to be at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to~~

~~performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 4. 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 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~~ examinations and tests for the screening for the early detection of cervical cancer. The coverage shall be in accordance with the most recently published American Cancer Society guidelines 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 5. This act becomes effective January 1, 2004, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 876

Short Title:	Meningitis Immunization.	(Public)
Sponsors:	Senators Purcell; and Bingham.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL IMMUNIZATION INFORMATION TO NEWLY ENROLLED STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningoccocal immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide information on meningococcal disease to each student who enrolls for the first time at that campus. The information about the meningococcal disease shall include all of the following:

(1) Symptoms, risks, especially as the risks relate to circumstances of group living arrangements, and treatment of the disease.

(2) A recommendation that each newly enrolled student receive the vaccination to prevent the student from contracting the disease and where the vaccination can be received.

(3) A response form with space in which to indicate that the newly enrolled student has received the information about meningococcal disease and the availability of the vaccine to prevent the student from contracting the disease, whether or not he or she has chosen to receive the vaccination and his or her signature. In the case of a student who is a minor, the student's parent or guardian shall sign the response form on behalf of the minor student.

(b) The student or the student's parent or guardian shall return the signed form to the appropriate office at the educational institution before enrollment. The information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningoccocal vaccination to students.

(d) Each educational institution required to provide information under this section shall consult with the Department of Health and Human Services regarding the preparation of the information materials for the newly enrolled students.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 876
PROPOSED COMMITTEE SUBSTITUTE S876-PCS75241-SW-12

Short Title: Meningococcal Meningitis Immunization Info. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new Article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningococcal disease immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide vaccination information on meningococcal disease to each student. The vaccination information shall be contained on student health forms provided to each student by the educational institution and shall include space for the student to indicate whether or not the student has received the vaccination against meningococcal disease. The vaccination information about meningococcal disease shall include any recommendations issued by the national Centers for Disease Control and Prevention regarding the disease.

(b) The vaccination information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningococcal vaccination to students.

(d) This section shall not apply if the national Centers for Disease Control and Prevention no longer recommends the meningococcal disease vaccination for the general population.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 876
PROPOSED COMMITTEE SUBSTITUTE S876-CSSW-12 [v.4]

4/14/2003 8:15:05 PM

Short Title: Meningococcal Meningitis Immunization Info. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningococcal disease immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide vaccination information on meningococcal disease to each student. The vaccination information shall be contained on student health forms provided to each student by the educational institution and shall include space for the student to indicate whether or not the student has received the vaccination against meningococcal disease. The vaccination information about meningococcal disease shall include any recommendations issued by the national Centers for Disease Control and Prevention regarding the disease.

(b) The vaccination information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningococcal vaccination to students.

(d) This section shall not apply if the national Centers for Disease Control and Prevention no longer recommends the meningococcal disease vaccination for the general population.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

SENATE BILL 876:
Meningococcal Meningitis Immunization Info.

BILL ANALYSIS

Committee:	Senate Health & Human Services	**Introduced by:**	Sen. Purcell
Date:	April 16, 2003	**Summary by:**	Sara Kamprath
Version:	PCS for First Edition S876-CSSW-12[v.4]		Committee Analyst

BILL ANALYSIS: Senate Bill 876 creates a new section in Chapter 116 of the General Statutes relating to certain public and private educational institutions with a residential campus providing vaccination information on meningococcal disease to each student. The vaccination information shall be included on the student health form provided to each student and shall include any recommendations from the Centers for Disease Control and Prevention regarding the disease. The health form shall provide space for the student to indicate whether he has received the vaccination. The vaccination information obtained under this section is confidential and shall not be a public record under G.S. 132-1.

The educational institution is not required to provide the meningococcal vaccination to students. If the national Centers for Disease Control and Prevention no longer recommends the meningococcal vaccination for the general population then the section does not apply. The section does not create a private right of action.

The bill is effective when it becomes law and applies beginning with the 2003-04 academic year.

BACKGROUND: G.S. 130A-155.1 provides that no person can attend a public, private or religious college or university without presenting a certificate of immunization or a record of immunization from a NC high school. The document must indicate that the person has received the immunizations required by G.S. 130A-152. If the information is not available when the person first registers then the person shall have a certain amount of time to get the required immunization. If the person has not received the immunization within that time period then the student will have to withdraw. Currently, the meningococcal vaccination is not required.

The Journal of the American Medical Association recently reported that freshmen living in dormitories have over a 6 times higher risk or meningococcal disease than college students overall. The Centers for Disease Control recommends that colleges and universities provide information about meningococcal disease and the vaccine to freshmen, especially those planning to live in dorms or residence halls.

VISITOR REGISTRATION SHEET

HEALTH & HUMAN SERVICES — **APRIL 17, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ANN LORE	DUHS
Pam Harrison	
Mary Doplan	APS
Camille Stoll	Kennedy Covington
Mac Mumbert	Poyner & Spruill
John Tate	Mental Health Assn
Mark Fleming	University System
Rob Lambert	NCDHHS
Ron McKillion	Moore + Van Allen
Rossa Ward	Hemophilia Health Services
Scott Sorenson	Hemophilia Health Services

VISITOR REGISTRATION SHEET

HEALTH & HUMAN SERVICES — **APRIL 17, 2003**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOHN WITHROW	NC STATEWATCH

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Thursday, April 23, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

- **SB 388, *Update Cervical Cancer Screening Coverage*, Sen. Foxx**
- **SB 986, *Students with Disabilities/Medicaid*, Sen. Reeves**

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 23, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, April 23, 2003 in Room 544 of the Legislative Office Building. Eleven members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Bingham, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Purcell asked Senator Foxx to present her bill, SB 388, *Update Cervical Cancer Screening Coverage*, to the committee. This bill had been heard at an earlier meeting, but needing an actuarial note, had not been voted upon. A proposed committee substitute was given to the committee members. (This committee substitute had been approved by the committee members at the earlier meeting.) Senator Bingham proposed an amendment to amend the coinsurance deductible amount, which would conform to another section of the General Statutes. Senator Forrester moved to accept the amendment. Senator Forrester moved for a favorable report for the committee substitute as amended and the motion passed

Senator Purcell recognized Senator Reeves to explain SB 986, *Students with Disabilities/Medicaid.* Susan Harrison of the Wake County School System explained the coordination between the school system and DHHS for students on Medicaid, and also the problems associated with providing Medicaid reimbursement to these students. Senator Allran asked if this bill was likely to significantly impact the Medicaid budget. Ms. Harrison responded that these are special funds that come to the state from the federal government which revert back if not used. Jim Bernstein of the Department of Health and Human Services said that existing funds from the school system would be matched with federal dollars. Senator Forrester moved for a favorable report, with a sequential referral to the Appropriations Committee.

The meeting adjourned at 11:33 A.M.

William R. Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, April 23, 2003

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

FAVORABLE

S.B. **986** Students with Disabilities/Medicaid.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Monday, April 28, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **388** Update Cervical Cancer Screening Coverage.

Draft Number:	PCS85220
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 388

Short Title:	Update Cervical Cancer Screening Coverage.	(Public)
Sponsors:	Senators Foxx; Allran, Apodaca, Bingham, Blake, Brock, Carpenter, Carrington, Dorsett, Forrester, Garrou, Garwood, Gulley, Hagan, Hargett, Hartsell, Horton, Jenkins, Kerr, Kinnaird, Lucas, Queen, Shubert, Sloan, Stevens, Swindell, Thomas, Tillman, and Weinstein.	
Referred to:	Health and Human Resources.	

March 12, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

The General Assembly of North Carolina enacts:

SECTION 1. 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 all of the following:

(1) Mammograms and ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer 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) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are 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. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The

same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

(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."

SECTION 2. G.S. 58-51-57 reads as rewritten:

"**§ 58-51-57. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets

mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission. ~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 58-65-92 reads as rewritten:

"**§ 58-65-92. Coverage for mammograms and ~~pap smears~~ cervical cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;
b. The woman has a personal history of biopsy-proven benign breast disease;
c. The woman's mother, sister, or daughter has or has had breast cancer; or
d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 59-67-76 reads as rewritten:

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is determined to be at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to~~

~~performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 4. 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 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~~ examinations and tests for the screening for the early detection of cervical cancer. The coverage shall be in accordance with the most recently published American Cancer Society guidelines 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 5. This act becomes effective January 1, 2004, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit 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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 388
PROPOSED COMMITTEE SUBSTITUTE S388-CSRM-13 [v.4]

4/15/2003 7:43:18 PM

Short Title: Update Cervical Cancer Screening Coverage. (Public)

Sponsors:

Referred to:

March 12, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

The General Assembly of North Carolina enacts:

SECTION 1. 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 all of the following:

(1) Mammograms and ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer 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) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are 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. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

(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."

SECTION 2. G.S. 58-51-57 reads as rewritten:

"**§ 58-51-57. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 58-65-92 reads as rewritten:

"**§ 58-65-92. Coverage for mammograms and ~~pap smears~~ cervical cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an

asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 4. G.S. 59-67-76 reads as rewritten:

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is determined to be at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation~~

~~standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission. ~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 5. 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 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~~ examinations and tests for the screening for the early detection of cervical cancer. The coverage shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for any covered female. For the purposes of this subsection, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis. 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 6. This act becomes effective January 1, 2004, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit 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.

SENATE BILL 388:
Update Cervical Cancer Screening Coverage

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Sen. Foxx
		Summary by:	Dianna Jessup Committee Counsel
Date:	April 16, 2003		
Version:	PCS S388-CSRM-13		

SUMMARY: ***Senate Bill 388 would specify that laboratory tests for cervical cancer screening must be covered under health benefit plans, replacing the term "pap smear". The act would become effective January 1, 2004 and apply to all new health benefit plans and renewals of plans on or after that date. For purposes of the act, renewal of a health benefit plan would be presumed to occur on the anniversary date of the policy.***

CURRENT LAW: Currently, small employer group insurance plans, health policy and preferred provider benefit plans, hospital service plans, medical service plans, HMO plans, and the State Health Plan cover pap smears, generally once a year. These plans are also required to cover mammograms. Reimbursement for mammograms and pap smears are made only if the facility in which the mammogram or pap smear was performed meets accreditation standards established by the North Carolina Medical Care Commission. The statutes provide for what standards apply for reimbursement if the Medical Care Commission has not adopted standards.

BILL ANALYSIS: Generally, the bill would delete "pap smear" and substitute "examinations and laboratory tests for the screening for the early detection of cervical cancer" throughout the health benefit plan statutes. The bill would define "examinations and laboratory tests for the screening for the early detection of cervical cancer" to mean conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis. The bill would also provide that coverage for the screening shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Reimbursement would be made only if the facility or the laboratory meets accreditation standards adopted by the Medical Care Commission.

Section 1 would make these changes to small employer group health insurance plans.

Section 2 would make these changes to health policy and preferred provider benefit plans.

Section 3 would make these changes to the hospital service plans and medical service plans.

Section 4 would make these changes to HMO health care plans.

Section 5 would make these changes to the State Health Plan.

Section 6 would make these changes effective January 1, 2004 and apply to all health benefit plans delivered, issued for delivered, or renewed on and after that date. For the purposes of the act, renewal of a health benefit plan would be presumed to occur on the anniversary date of the plan.

S388-SMSW-001

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 388, Sections 4 & 5

SHORT TITLE: Update Cervical Cancer Screening Coverage

SPONSOR(S): Sen. Foxx

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, premium payments for coverages selected by eligible former teachers and State employees and premium payments for coverages selected by firefighters, rescue squad workers, and members of the National Guard.

BILL SUMMARY: The bill replaces the Plan's coverage of one Pap smear per year in its coverage for routine diagnostic examinations with whatever guidelines are published by the American Cancer Society for examinations and tests for the early detection of cervical cancer.

EFFECTIVE DATE: January 1, 2004

ESTIMATED IMPACT ON STATE: Based upon information provided by the Plan, both Aon Consulting, consulting actuary for the Plan, and Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimate the bill will result in cost savings to the Plan. These estimates are based upon the American Cancer Society's current guidelines on examinations and tests for the early detection of cervical cancer. Aon consulting projects a cost savings to the Plan of $70,000 for fiscal year 2003-04 and a cost savings of $300,000 for fiscal year 2004-05. Hartman & Associates estimates a cost savings to the Plan of $117,000 for fiscal year 2003-04 and a cost savings of $394,000 for fiscal year 2004-05.

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 only had 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., $350 annual deductible, 20% coinsurance up to $1,500 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. Beginning in July 2000, firefighters, rescue squad workers, and members of the National Guard and their eligible dependents were allowed to voluntarily participate in the Plan on a fully contributory basis, provided they were ineligible for any other type of group health benefits and had been without such benefits for at least six months. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully

contributory, except for job-sharing public school teachers who are authorized partially contributory premiums at 50% of non-contributory rates. The Plan's Executive Administrator has set the premium rates for firefighters, rescue squad workers, and members of the National Guard and their families at 20% more than the comparable rates charged for employees, retired employees, and their families. 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; however, none of the HMOs with certificates of authority to transact business in North Carolina have offered to participate in the Plan since September 30, 2001. 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, 2002, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	280,065	-0-	280,065
Active Employee Dependents	137,841	-0-	137,841
Retired Employees	117,225	-0-	117,225
Retired Employee Dependents	18,999	-0-	18,999
Former Employees & Dependents with Continued Coverage	2,535	-0-	2,535
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	7	-0-	7
Total Enrollments	556,672	-0-	556,6
Number of Contracts			
Employee Only	313,439	-0-	313,439
Employee & Child(ren)	40,978	-0-	40,978
Employee & Family	44,710	-0-	44,710
Total Contracts	399,127	-0-	399,127
Percentage of Enrollment by Age			
29 & Under	26.9%	-0-%	26.9%
30-44	20.9	-0-	20.9
45-54	20.9	-0-	20.9
55-64	16.2	-0-	16.2
65 & Over	15.1	-0-	15.1
Percentage of Enrollment by Sex			
Male	38.3%	-0-%	38.3%
Female	61.7	-0-	61.7

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2002, the self-insured program started its operations with a beginning cash balance of $91.6 million. Receipts for the year are estimated to be $1.371 billion from premium collections and $7 million from investment earnings for a total of $1.378 billion in receipts for the year. Disbursements from the self-insured program are expected to be

$1.335 billion in claim payments and $38 million in administration and claims processing expenses for a total of $1.373 billion for the year beginning July 1, 2002. For the fiscal year beginning July 1, 2002, the self-insured indemnity program is expected to have a net operating gain of approximately $14 million for the year. Without reserving an additional $15 million for implementation of the claims data and privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPPA) that take effect on and after April 14, 2003, the Plan's self-insured indemnity program is expected to have an available beginning cash balance of $96 million for the fiscal year beginning July 1, 2003. The self-insured indemnity program is nonetheless assumed to be unable to carry out its operations for the 2003-2005 biennium without increases in its current premium rates or a reduction in existing benefits or payments to health care providers or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, discounts on hospital outpatient services, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $186.04 monthly for employees whose primary payer of health benefits is Medicare and $244.38 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $115.78 monthly for children whose primary payer of health benefits is Medicare and $152.32 monthly for other covered children, and $277.68 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $365.36 per month for other family contract dependents. Claim cost trends are expected to increase 12% annually. Total enrollment in the program is expected to increase less than 1% annually over the next two years. The number of enrolled active employees is expected to show no increase over the next two years, whereas the growth in the number of retired employees is assumed to be 5% per year. The program is expected to have a 2% decrease in the number of active employee dependents per year whereas the number of retiree dependents is expected to increase 2% per year. Investment earnings are based upon a 4.5% 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 the Indemnity Plan's Coverage of Screening for Cervical Cancer: New guidelines addressing when and how often women should get early detection tests for cervical cancer and pre-cancer were issued November 14, 2002, by the American Cancer Society. Based on the new recommendations, most women would begin cervical cancer screening later, have an option to stop at a certain age, and be exempt from screening entirely if they have had a hysterectomy. The new guidelines are expected to have a major impact on the number of women who are over-screened and over-treated. Because most cervical pre-cancers grow slowly, having a test every two to three years will find almost all cervical pre-cancers and cancers while they can be removed or treated successfully, according to medical experts with the American Cancer Society. The Society, however, notes that the biggest gain in reducing cervical cancer incidence and mortality would be achieved by increasing screening rates among women who have not been screened or who have not been screened regularly.

The new guidelines, in summary form, are:

- Cervical cancer screening should begin about three years after a woman begins having vaginal intercourse, but no later than 21 years of age.
- Cervical screening should be done every year with regular Pap tests or every two years using liquid-based Pap tests. At or after age 30, women who have had three normal test results in a row may get screened every two to three years. A doctor may suggest getting the test more often if a woman has certain risk factors such as human immunodeficiency virus (HIV) infection or a weakened immune system.
- Women 70 years of age and older who have had three or more normal Pap test results and no abnormal results in the last 10 years may choose to stop cervical cancer screening.
- Screening after a total hysterectomy (with removal of the cervix) is not necessary unless the surgery was done as a treatment for cervical cancer or pre-cancer. Some other special conditions may require continued screening. Women who have had a hysterectomy without removal of the cervix should continue cervical cancer screening at least until age 70. In addition, a promising new test for human papilloma virus (HPV), not yet approved for screening by the FDA, may be useful in detecting early cervical cancer in women over 30 years of age. If the test is approved, it may be added to the guidelines.

The ACS estimates that 13,000 women will develop invasive cervical cancer this year, and about 4,100 women will die of the disease.

For the last two fiscal years, the Plan's claims experience for cervical cancer screenings has been:

			Member Ages		
Group	Up to 17	18-34	35-54	55 & Over	Total
FY2002					
No. of Screenings					
Active	771	23,811	49,088	10,748	84,418
Retired (Non-Medicare)	37	383	2,313	8,071	10,804
Total	808	24,194	51,401	18,819	95,222
Cost of Screenings					
Active - Charge	$22,421	$697,424	$1,421,588	$304,383	$2,445,817
Active - Paid	$19,190	$597,894	$1,115,279	$231,512	$1,963,876
Retired - Charge	$1,214	$10,923	$66,198	$227,199	$305,533
Retired - Paid	$971	$9,154	$49,984	$175,302	$235,410
Total - Charge	$23,634	$708,347	$1,487,787	$531,582	$2,751,350
Total - Paid	$20,161	$607,048	$1,165,263	$406,814	$2,199,286
FY2001					
No. of Screenings					
Active	632	19,344	42,874	9,007	71,857
Retired (Non-Medicare)	26	308	1,994	6,935	9,263
Total	658	19,652	44,868	15,942	81,120
Cost of Screenings					
Active - Charge	$21,425	$664,273	$1,434,993	$297,321	$2,418,012
Active - Paid	$17,159	$509,134	$1,043,982	$217,789	$1,788,064
Retired - Charge	$986	$10,632	$66,261	$225,665	$303,544
Retired - Paid	$824	$8,091	$48,614	$166,856	$224,385
Total - Charge	$22,411	$674,905	$1,501,253	$522,986	$2,721,556
Total - Paid	$17,982	$517,225	$1,092,596	$384,645	$2,012,449

Over the last two fiscal years, the Plan had has the following number of cervical cancer cases with the amount of allowable charges and paid claims:

	FY2002				FY2001			
Member Age (Years)	No. of Cases	% of Cases	Claim Payments	% of Claims	No. of Cases	% of Cases	Claim Payments	% of Claims
6-10	1	0.1%	$0	0.0%	1	0.1%	$0	0.0%
11-15	0	0.0%	$0	0.0%	1	0.1%	$28	0.0%
16-20	6	0.4%	$696	0.1%	13	1.0%	$3,293	0.4%
21-25	4	0.3%	$177	0.0%	8	0.6%	$1,952	0.2%
26-30	12	0.8%	$1,295	0.1%	14	1.0%	$5,941	0.7%
31-35	67	4.6%	$37,845	4.3%	29	2.1%	$1,887	0.2%
36-40	39	2.7%	$23,451	2.7%	168	12.3%	$121,753	14.6%
41-45	295	20.1%	$274,318	31.3%	217	15.9%	$185,411	22.2%
46-50	165	11.2%	$79,264	9.0%	81	5.9%	$44,724	5.3%
51-55	140	9.5%	$126,953	14.5%	186	13.6%	$160,180	19.2%
56-60	228	15.5%	$77,233	8.8%	196	14.4%	$161,961	19.4%
61-65	154	10.5%	$203,359	23.2%	148	10.9%	$98,641	11.8%
66-70	147	10.0%	$35,276	4.0%	125	9.2%	$37,794	4.5%
71-75	44	3.0%	$2,165	0.2%	27	2.0%	$194	0.0%
76 & Over	166	11.3%	$15,736	1.8%	149	10.9%	$12,304	1.5%
Total	1,468	100.0%	$877,768	100.0%	1,363	100.0%	$836,063	100.0%

For the last three fiscal years, the Plan has had the following average quarterly number of females, aged 15 and older, enrolled:

	Female Enrollees Aged 15 & Older		
Age (Years)	FY2002	FY2001	FY2000
15-19	15,025	13,839	11,994
20-24	16,112	14,090	11,224
25-29	18,791	16,070	12,687
30-34	22,167	18,204	13,730
35-39	23,451	20,791	17,466
40-44	29,600	26,948	23,565
45-49	36,444	33,156	28,959
50-54	38,011	33,786	28,265
55-59	29,087	24,391	21,220
60-64	21,317	19,097	17,343
65-69	16,180	15,292	14,289
70-74	13,262	12,745	12,239
75-79	10,172	9,850	9,516
80 & Over	13,724	13,064	12,480
Total	303,341	271,321	234,976

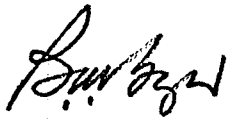
SOURCES OF DATA:

- Actuarial Note, Hartman & Associates, Senate Bill 388, April 18, 2003, original of which is on file in the General Assembly's Fiscal Research Division.
- Actuarial Note, Aon Consulting, Senate Bill 388, April 17, 2003, 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: Although Section 4 of the bill amends G.S. 135-40.5(e), Routine Diagnostic Examinations, a further amendment needs to be made to G.S. 135-40.6(8)s. Benefits under G.S. 135-40.5(e) are paid without application of the Plan's annual deductible and coinsurance, which are the responsibility of Plan members, up to $150 per person per year. G.S. 135-40.6(8)s. needs a conforming amendment so that any allowed charges exceeding $150 per person per year are also covered even though annual deductibles and coinsurance are applied to the allowed charges.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Sam Byrd



APPROVED BY: James D. Johnson, Director, Fiscal Research Division

DATE: April 22, 2003

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 388

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

S388-ASW-10 [v.2]

Date _____,2003

Comm. Sub. [YES]
Amends Title [NO]
S388-CSRM-13

Senator _____

moves to amend the bill on page 6, lines 41-42, by inserting between the lines the following:

"**SECTION 5.(a).** G.S. 135-40.6(8)s. reads as rewritten:

...

s. Routine Diagnostic Examinations: Allowable charges for routine diagnostic examinations and tests, including ~~Pap smears,~~ examinations and tests for the screening for the early detection of cervical cancer, 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, and, for examinations and tests for the screening for the early detection of cervical cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. 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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 388

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

S388-ASW-10 [v.2]

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. For purposes of this subdivision, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis."

...".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 986

Short Title:	Students with Disabilities/Medicaid.	(Public)
Sponsors:	Senators Reeves; Clodfelter and Foxx.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO WORK WITH THE DEPARTMENT OF PUBLIC INSTRUCTION AND LOCAL EDUCATION AGENCIES TO ENSURE MAXIMUM FUNDING FOR MEDICAID-RELATED SERVICES FOR ELIGIBLE PUBLIC SCHOOL STUDENTS WITH DISABILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-55.1. Collaboration among agencies to ensure Medicaid-related services payments to eligible students with disabilities in public schools.**

The Department shall work with the Department of Public Instruction and local education agencies to develop efficient, effective, and appropriate administrative procedures and guidelines to provide maximum funding for Medicaid-related services for Medicaid-eligible students with disabilities. The procedures and guidelines shall be streamlined to ensure that local education agencies receive Medicaid reimbursement in a timely manner for Medicaid-related services and administrative outreach to Medicaid-eligible students with disabilities."

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

VISITOR REGISTRATION SHEET

HEALTH & HUMAN RESOURCE — **Name of Committee**

APRIL 23, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Watson	NCDPI
Steve Hoffman	NCSBA
Terry Hales by	NCPC/[illegible]
Steve Mitchell	Novartis
Evelyn Hawthorne /	EHGR
Stacy Flannery	NCHCFA
Jerry Ludlow	NCSBA
Ken Melton	Alley Associates, INC.
Raul Martinez	Tijuana Council
BRIAN SHANK	ASTRAZENECA
Lon Wilson	NCALYC7.

VISITOR REGISTRATION SHEET

HEALTH & HUMAN RESOURCE — **APRIL 23, 2003**
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
Charity Potts	Northwest Alliance Community Dev. Corp.
[illegible]	The Arc
[illegible]	APAB
Paula McKenney	PHHS
[illegible]	DHHS
Joanne Stevens	nursing

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 30, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

• **SB 1016**	***Nursing Home/Medication Errors***	**Sen. Berger**
• **SB 582**	***Public Schools/Healthy Kids***	**Sen. Purcell**
• **SB 975**	***Accessible Electronic Info Act/Blind/Disab'd***	**Sen. Dorsett**

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, April 30, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, April 30, 2003 in Room 544 of the Legislative Office Building. Nine members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator William Purcell, Co-Chair welcomed the committee members present.

Senator Kinnard made the motion to waive the rule to consider the PCS being heard today for the purpose of discussion which passed unanimously. Sen. Bingham recognized Senator Berger to present Senate Bill 1016, ***Nursing Home/Medication Errors***. The PCS was changed and Dianna Jessup was recognized to explain the second version. Senator Kinnard moved for a favorable report at the appropriate time. Senator Forestry stated that he is a medical director of a couple of nursing homes and it looks like they are doing this already and he does support the bill. Senator Queen ask if there was someone from the industry that could speak on the bill.

Ms. Stacey Flaner with the NC Health Care Facility Association who represents the skilled nursing faculitites in NC noted that skilled nursing home facilities in NC have a very low medication error rate. It is less than 1%. They do have internal reporting mechanism but this bill will take it a step further in formalizing the reporting process for those errors and will assist facilities in setting up a model so that they can analyze those errors and work on them internally. Reporting outside the facility would hopefully go through Medical Review of NC, which is a perfect place, they constantly work with nursing facilities in NC on quality initiatives.

Mr. Jackie Shephard, Division of Facilitates Services in the Department of Health and Human Services, stated their main concern being the requirement for contracting with an outside entity, there will be cost involved and they would suggest that it be conditional upon there being federal funds available because this project will compete with other funding priority in the Governor's budget. We would need some conditional language. There is a federal civil monetary penalty from which they may be able to use funds to support such an initiative, however it is not automatic, they would have to request federal approval for use of those funds. It is strictly tied to Nursing Homes where there have been some deficiency practices involved. They do not know how much the contract will cost but that is their primary concerns.

Senator Berger stated it was his understanding that the money, that would be necessary, would be dealt with by Medical Review of NC and that they had some grant funds to take care of this.

Senator Lucas made a motion to amend the bill to specify the use of the civil monetary penalty fund so as not to use state appropriations funds. Senator Berger wanted to broaden the amendment to include grant money also.

While Staff drafted the amendment Senator Bingham recognized the Senate Pages.

Senator Malone asked Senator Berger if he had considered a patient member as one of the members on the Medication Management Advisory Committee. They did consider but decided against it because the nursing faculties currently are required to have a Quality Assurance Committee and they are trying to work within the existing structure so as not to place on the nursing facilities any addition cost having a separate committee. Also there were concerns about HIPPA issues and disclosing information to someone who was not a professional. Senator Lucus moved to amend the bill on page 7 line 16 Section 2, the department should use available grants and federal funds to implement GS131E-128.5 as enacted and becomes effective Jan. 1, 2004. The amendment passed unanimously.

Senator Dannley made the motion to roll the amendment into a new PCS, favorable report for new PCS unfavorable to original bill, which passed unanimously.

Senator Bingham recognized Senator Purcell to present SB 582, ***Public Schools/Healthy Kids***, which has a PCS. Senator Forestry made a motion to discuss the PCS which passed unanimously. The original bill required local boards of education to adopt policy and standards and practice in the provision of food services in public schools. We decided we were not ready for that so basically it establishes a commission on obesity and outlines who will be on that committee. Senator Dannelly stated it was a good bill and moved for a favorable report on the PCS unfavorable to the original bill, which passed unanimously. The bill will go to a study committee.

Senator Bingham recognized Senator Dorsett to present SB 975, ***Accessible Electronic Info Act/Blind/Disabled***, which has a PCS that is being passed out. Senator Lucus moved the PCS be adopted for discussion. Motion carried. Senator Dorsett explained that the bill speaks to accessible electronic information for the blind. It would require the division of services for the blind to establish and administer a state wide accessible electronic information service for the eligible blind and disabled persons. It will also direct the NC Utilities Commission to require all local communications companies to impose a sir charge, if necessary, on subscribers so a fund can be set up for accessible electronic information. The change in the bill was the original bill had a $70,000. appropriation to the department of health and human services for this and now we believe there are other ways we can do it. For example GS-62-157 set up a telecommunication relay system but it was really designed for telephone services to provide access for the hearing impaired and the speech impaired persons including those with vision impairments. Senator Bingham stated it had to be referred to finance. With that being said, Senator Lucas moved for a favorable report for the PCS unfavorable to original bill. The motion carried.

The meetings adjourned.

Senator Stan Bingham, Co-Chair

Senator William R, Purcell, CoChair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, April 30, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **582** Public Schools/Healthy Kids.

Draft Number:	PCS85230
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **975** Accessible Electronic Info Act/Blind/Disab'd.

Draft Number:	PCS65288
Sequential Referral:	None
Recommended Referral:	Finance
Long Title Amended:	Yes

S.B. **1016** Nursing Home/Medication Errors.

Draft Number:	PCS40038
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 1016

Short Title:	Nursing Home/Medication Errors.	(Public)
Sponsors:	Senator Berger.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new sections to read:

"**§ 131E-128.1. Nursing home medication management advisory committee.**

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

(1) 'Advisory committee' means a medication management committee established under this section to advise the quality assurance committee.

(2) 'Medication-related error' means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(3) 'Nursing home' means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.

(4) 'Potential medication-related error' means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.

(5) 'Quality assurance committee' means a quality assurance committee established in accordance with federal and State regulations to identify

issues with respect to which quality assessment and assurance activities are necessary and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes to identify medication-related errors, evaluate causes, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

(1) The director of nursing.

(2) The consultant pharmacist.

(3) A physician designated by the nursing home administrator.

(4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The pharmacist shall chair the advisory committee.

(e) Confidentiality. – The administrator shall ensure that a record is maintained of each meeting:

(1) The meetings or proceedings of the advisory committee, the records and materials it produces and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and G.S. 131E-128.5 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, 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 nursing home licensed under this Article, 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 may testify in any civil action as to any evidence or other matters produced or presented during the meetings or 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~~available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, are not immune from discovery or use in a civil action merely because they were presented during meetings or 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 opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and is not subject to discovery or use in civil actions under subdivision (1) of this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to that which is reasonably necessary and relevant to the standards review organizations' determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under subdivision (1) of this subsection, and the standards review organization shall keep the information confidential subject to subdivision (1) of this subsection.

(3) Information that is confidential and is not subject to discovery or use in civil actions under subdivision (1) of this section may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to that which is reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in subdivision (1) of this subsection, and the Department shall keep the information confidential subject to subdivision (1) of this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under subdivision (1) of this section may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to that which is reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in subdivision (1) of this subsection, and the occupational licensing board shall keep the information confidential subject to subdivision (1) of this subsection.

(f) Duties. – The advisory committee shall do the following:

(1) Assess the facility's pharmaceutical management system, including, prescribing, distribution, and administration policies, procedures, and practices and identify areas at high risk for medication-related errors.

(2) Review the facility's pharmaceutical management quality indicators and respond accordingly to ensure that these indicators are being met.

(3) Review, investigate, and respond to facility incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.

(4) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.

(5) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

(6) Identify goals and recommendations for the implementation of best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.

(7) Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system within the facility of actual and potential medication-related errors.

(8) Develop specifications for drug administration documentation procedures to ensure compliance with federal and State law.

(9) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures as to which patients may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, 131E-128.4, or 131E-128.5.

"**§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.**

(a) Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this subsection. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee:

(1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.

(2) Increase prescription legibility.

(3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.

(4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.

(5) Implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.

(6) Reduce confusion that may result from similar-sounding drug names.

(7) Implement a system to accurately identify recipients before any drug is administered.

(8) Implement policies and procedures to ensure that medications are accurately administered and documented by properly authorized individuals, in accordance with prescribed orders and stop order policies.

(9) Implement policies and procedures for the self-administration of medication.

"**§ 131E-128.3. Staff orientation on medication error prevention.**

(a) The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

(1) General information relevant to the administration of medications including terminology, procedures, and routes of medication administration, and potential side effects and adverse reactions.

(2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.

(3) The facility's policy and procedures regarding its medication administration system.

(4) How to assist patients with safe and accurate self-administration, where appropriate.

(5) Identifying and reporting actual and potential medication-related errors.

"**§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.**

(a) The consultant pharmacist shall conduct a drug regimen review for actual and potential drug therapy problems and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

(1) Drug therapy which may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.

(2) Monitoring for potential adverse effects.

(3) Allergies.

(4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
(5) Contraindications and precautions.
(6) Potential therapeutic duplication.
(7) Over-extended length of treatment of certain drugs typically prescribed for a short period of time.
(8) Beer's listed drugs which are potentially inappropriate for use by elderly persons.
(9) Under treatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
(10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record including the medication administration records and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The pharmacist consultant shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety.

"**§ 131E-128.5. Medication-related error reports to Secretary of Health and Human Services.**

(a) A nursing home shall annually submit to the Secretary of Health and Human Services a report on the nursing home's medication-related errors. The report shall not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The report shall include the following:

(1) The total number of medication-related errors for the preceding year.

(2) A listing, by category, of the types of medication-related errors, the number of medication-related errors in each category, the root cause analysis of each category of error, and the staff level involved.

(3) A listing, by category, of the types of injury caused and the number of injuries occurring within each category.

(4) Types of liability claims filed based on an adverse incident or reportable injury.

(b) The Department shall analyze the medication-related error reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1, and the Department shall keep the information confidential subject to that section."

SECTION 2. This act becomes effective January 1, 2004.

SENATE BILL 1016:
Nursing Home/Medication Errors

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Sen. Berger
Date:	April 30, 2003	**Summary by:**	Dianna Jessup
Version:	S1016-CSLN-17 [v.1]		Committee Counsel

SUMMARY: ***The PCS to Senate Bill 1016 would require nursing homes to establish medication management advisory committees. The PCS would also require every nursing home administrator to ensure that the nursing home quality assurance committee implements measures to minimize risk of medication-related errors. Staff training regarding prevention of medication errors would be required, and consultant pharmacists would be required to conduct certain drug regimen reviews and make certain reports. Finally, the Department of Health and Human Services would be required to contract with a third party to develop and implement a Medication Error Quality Initiative. The act would become effective January 1, 2004.***

CURRENT LAW: According to the Division of Facility Services of the Department of Health and Human Services, there are no requirements that make nursing homes report medication errors to a State regulatory agency. Each nursing home handles medication errors in a different way. Usually, nursing homes develop a form used to report medication errors that is processed by the nursing home administrator or the pharmacy committee.

Regulatory requirements regarding nursing homes and medication errors:

- Nursing homes must ensure that medications are administered in accordance with standards of professional practice and applicable occupational licensure regulations. (NCAC 10-3H.2306)
- The omission of a medication to a resident must be documented and reasons for the omission cited in the resident's medical record. (NCAC 10-3H.2306)
- Nursing homes must provide pharmaceutical services under the supervision of a pharmacist, including procedures that ensure the accurate acquiring, receiving and administering of all drugs and biologicals. (NCAC 10-3H.2601)
- Nursing homes must require the licensed pharmacist review each resident's drug regimen at least once a month to ensure that residents' drug use is safe and effective, and that facilities are in compliance with federal and State regulations. The pharmacist must report any irregularities to the attending physician and the director of nursing. (NCAC 10-3H.2601 and 10-3H.2603)
- Nursing homes must act to correct reported irregularities. (NCAC 10-3H.2603)
- Each resident's drug regimen must be free of any drugs used in excessive dose or duration, including duplicate drug therapy, or uses without adequate monitoring, or without adequate indications for its use. (NCAC 10-3H.2306)
- Nursing homes must reduce or discontinue drugs when there is an indication that the drug is causing adverse consequences. (NCAC 10-3H.2306)

- Nursing homes must ensure that antipsychotic drugs are administered only as part of a treatment plan, and may only be given if the antipsychotic drug therapy is necessary to treat a specific condition that is diagnosed and documented in the clinical record. (NCAC 10-3H.2306)
- Nursing homes must ensure that residents only self-administer medications when certain conditions are met to ensure the resident's safety. (NCAC 10-3H.2306)
- Nursing homes must maintain a quality assessment and assurance committee that must meet at least quarterly to identify deficiencies and develop plans of action to correct them. (NCAC 10-3H.2212) *The State cannot require disclosure of the records of these committees.
- The Board of Pharmacy has adopted rules applicable to drug distribution in nursing homes governing the following: (1) medication orders, (2) devices, (3) labeling, (4) automated dispensing, and (5) record keeping. Medication errors resulting from the administration of an incorrect medication or dose must be documented and reported to the pharmacist manager. These records must be maintained for three years.

BILL ANALYSIS:

Medication Management Advisory Committee

The PCS to Senate Bill 1016 would require every nursing home to establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The advisory committee would consist of the nursing home administrator and at lease the following members appointed by the nursing home administrator:

1. The director of nursing.
2. The consultant pharmacist.
3. A physician designated by the nursing home administrator.
4. At least three other members of the nursing home staff.

The advisory committee would meet as needed but no less than quarterly. The Director of Nursing or Staff Development Coordinator would be the chair. The administrator must maintain a record of certain proceedings and information.

DUTIES of the Advisory Committee: The Advisory Committee would have the following duties:

1. Assess the facility's pharmaceutical management system and practices and identify areas at high risk for medication-related errors.
2. Review the facility's pharmaceutical management goals and make sure goals are being met.
3. Review, investigate, and respond to facility incident reports and resident grievances.
4. Identify goals and recommendations for the implementation of best practices.
5. Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system.
6. Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the NC Nursing Practice Act.

7. Develop specifications for self-administration of drugs by qualified patients in accordance with law.

Nursing Home Quality Assurance Committee

As part of its requirement to minimize risk of medication-related error, every nursing home quality assurance committee would have the following duties:

1. Educate and make the patient and the patient's family members aware of all the medications the patient is using.
2. Increase prescription legibility.
3. Minimize confusion in prescription drug labeling and packaging.
4. Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.
5. To the extent practicable, implement proven medication safety practices.
6. Educate facility staff engaged in medication administration.
7. Implement a system to accurately identify recipients before any drug is administered.
8. Implement policies and procedures designed to improve accuracy in medication administration and in documentation.
9. Implement policies and procedures for the self-administration of medication.
10. Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.
11. Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

Staff Orientation on Medication Error Prevention

Upon orientation and annually thereafter, the nursing home must provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors for all nonphysician personnel involved in direct patient care.

Nursing Home Pharmacy Reports and Duties of Consultant Pharmacist

This new statute would require consultant pharmacists of nursing homes to undertake certain drug regimen reviews, make reports concerning drug irregularities, drug product defects and adverse drug reactions, ensure proper documentation of allergies and adverse effects, and ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders.

Medication-Related Error Reports

The Secretary of Health and Human Services must contract with a public or private entity to develop and implement a Medication Error Quality Initiative. As part of the Initiative, each nursing home must report annually on the nursing home's medication-related errors. The report submitted by each nursing home would not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The contracting entity would analyze the reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor

would retain its confidentiality and would not be subject to discovery or use in any civil action as provided under this act.

BACKGROUND: According to the Agency for Healthcare Research and Quality[1], about 7,000 people per year die from medication errors, about 16% more deaths than the number attributable to work-related injuries. The cost associated with these medical errors in lost income, disability, and health care is as much as $29 billion annually. The Harvard School of Public Health and the Henry J. Kaiser Family Foundation performed a survey examining the views of 831 physicians and 1,207 adults in April-July of 2002. The survey found that 42% of public respondents and more than one third of U.S. physicians said that they or one of their family members had experienced medical errors in receiving medical care. Physicians said that among the leading causes of errors are a shortage of nurses and overwork, stress or fatigue of health professionals. The Agency for Healthcare Research and Quality emphasized that medical errors can occur anywhere in the health care system including: (1) hospitals, (2) clinics, (3) outpatient surgery centers, (4) doctors' offices, (5) nursing homes, (6) pharmacies, and (7) patients' homes. The errors can involve: (1) medicines, (2) surgery, (3) diagnosis, (4) equipment, and (5) lab reports. In December 2000, the U.S. Pharmacopeia released its first national report on medication error data collected from *hospitals*. The report indicates that the three most frequently reported types of errors were:

1. Omission errors (failure to administer an ordered medication dose);
2. Improper dose or quantity errors (any medication dose, strength or quantity that differs from that prescribed); and
3. unauthorized drug errors (the medication dispensed and/or administered was not authorized by the prescriber; includes wrong drug errors).

Reporting Requirements: Mandatory versus Voluntary: Currently, 17 states have laws or regulations requiring mandatory reporting of medical errors or adverse events in *hospitals*. According to the National Academy of State Health Policy, five states (including North Carolina) and the District of Columbia have voluntary reporting systems in place.

Amy Compeau, Research Assistant, contributed to this summary.

S1016-SMSW-001

[1] The Agency for Healthcare Research and Quality is the Nation's lead Federal agency for research on health care quality, costs, outcomes, and patient safety. It is the research arm of the U.S. Department of Health and Human Services.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 1016
PROPOSED COMMITTEE SUBSTITUTE S1016-CSLN-17 [v.1]

4/28/2003 4:27:46 PM

Short Title: Nursing Home/Medication Errors. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new sections to read:

"**§ 131E-128.1. Nursing home medication management advisory committee.**

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

(1) 'Advisory committee' means a medication management committee established under this section to advise the quality assurance committee.

(2) 'Medication-related error' means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(3) 'Nursing home' means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.

(4) 'Potential medication-related error' means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.

(5) 'Quality assurance committee' means a quality assurance committee established in accordance with federal and State regulations to identify issues with respect to which quality assessment and assurance activities are necessary and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes to identify medication-related errors, evaluate causes, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

(1) The director of nursing.

(2) The consultant pharmacist.

(3) A physician designated by the nursing home administrator.

(4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The Director of Nursing or Staff Development Coordinator shall chair the advisory committee.

(e) Confidentiality. – The administrator shall ensure that a record is maintained of each meeting:

(1) The meetings or proceedings of the advisory committee, the records and materials it produces and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and G.S. 131E-128.5 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, 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 nursing home licensed under this Article, 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 may testify in any civil action as to any evidence or other matters produced or presented during the meetings or 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~~available, including any deficiencies found

in the course of an inspection conducted under G.S. 131E-105, are not immune from discovery or use in a civil action merely because they were presented during meetings or 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 opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and is not subject to discovery or use in civil actions under subdivision (1) of this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to that which is reasonably necessary and relevant to the standards review organizations' determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under subdivision (1) of this subsection, and the standards review organization shall keep the information confidential subject to subdivision (1) of this subsection.

(3) Information that is confidential and is not subject to discovery or use in civil actions under subdivision (1) of this section may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to that which is reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in subdivision (1) of this subsection, and the Department shall keep the information confidential subject to subdivision (1) of this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under subdivision (1) of this section may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to that which is reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in subdivision (1) of this subsection, and the occupational licensing board shall keep the information confidential subject to subdivision (1) of this subsection.

(f) Duties. – The advisory committee shall do the following:

(1) Assess the facility's pharmaceutical management system, including, prescribing, distribution, and administration policies, procedures, and practices and identify areas at high risk for medication-related errors.

(2) Review the facility's pharmaceutical management goals and respond accordingly to ensure that these goals are being met.

(3) Review, investigate, and respond to facility incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.

(4) Identify goals and recommendations for the implementation of best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.

(5) Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system within the facility of actual and potential medication-related errors.

(6) Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the North Carolina Nursing Practice Act.

(7) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures as to which patients may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, 131E-128.4, or 131E-128.5.

"**§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.**

(a) Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this subsection. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee:

(1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.

(2) Increase prescription legibility.

(3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.

(4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.

(5) To the extent practicable, implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.

(6) Educate facility staff engaged in medication administration activities on similar-sounding drug names.

(7) Implement a system to accurately identify recipients before any drug is administered.

(8) Implement policies and procedures designed to improve accuracy in medication administration and in documentation by properly authorized individuals, in accordance with prescribed orders and stop order policies.

(9) Implement policies and procedures for the self-administration of medication.

(10) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.

(11) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

"**§ 131E-128.3. Staff orientation on medication error prevention.**

(a) The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

(1) General information relevant to the administration of medications including terminology, procedures, and routes of medication administration, and potential side effects and adverse reactions.

(2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.

(3) The facility's policy and procedures regarding its medication administration system.

(4) How to assist patients with safe and accurate self-administration, where appropriate.

(5) Identifying and reporting actual and potential medication-related errors.

"**§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.**

(a) The consultant pharmacist shall conduct a drug regimen review for actual and potential drug therapy problems and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

(1) Drug therapy which may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.
(2) Monitoring for potential adverse effects.
(3) Allergies.
(4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
(5) Contraindications and precautions.
(6) Potential therapeutic duplication.
(7) Over-extended length of treatment of certain drugs typically prescribed for a short period of time.
(8) Beer's listed drugs which are potentially inappropriate for use by elderly persons.
(9) Under treatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
(10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record including the medication administration records and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The pharmacist consultant shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety.

"**§ 131E-128.5. Medication-related error reports.**

(a) The Secretary of Health and Human Services shall contract with a public or private entity to develop and implement a Medication Error Quality Initiative. The Initiative would provide for, among other things, receipt and analysis by the contracting entity of annual reports from each nursing home on the nursing home's medication-related errors. The report submitted by the nursing home shall not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The report shall include the following:

(1) The total number of medication-related errors for the preceding year.

(2) A listing of the types of medication-related errors, the number of medication-related errors, the root cause analysis of each error, and the staff level involved.

(3) A listing of the types of injury caused and the number of injuries occurring.

(4) Types of liability claims filed based on an adverse incident or reportable injury.

(b) The contracting entity shall provide for analysis of the medication-related error reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1, and contractor shall keep the information confidential subject to that section."

SECTION 2. This act becomes effective January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 1016
PROPOSED COMMITTEE SUBSTITUTE S1016-CSSW-31 [v.2]

4/30/2003 10:25:39 AM

Short Title: Nursing Home/Medication Errors. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new sections to read:

"**§ 131E-128.1. Nursing home medication management advisory committee.**

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

(1) 'Advisory committee' means a medication management committee established under this section to advise the quality assurance committee.

(2) 'Medication-related error' means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(3) 'Nursing home' means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.

(4) 'Potential medication-related error' means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.

(5) 'Quality assurance committee' means a quality assurance committee established in accordance with federal and State regulations to identify issues with respect to which quality assessment and assurance activities are necessary and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes in identifying medication-related errors, evaluate the causes of those errors, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

(1) The director of nursing.

(2) The consultant pharmacist.

(3) A physician designated by the nursing home administrator.

(4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The Director of Nursing or Staff Development Coordinator shall chair the advisory committee. The nursing home administrator shall ensure that a record is maintained of each meeting.

(e) Confidentiality. – The meetings or proceedings of the advisory committee, the records and materials it produces and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and G.S. 131E-128.5 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, shall be confidential and not considered public records within the meaning of G.S. 132-1, "Public records defined". The meetings or proceedings and records and materials also shall not be subject to discovery or introduction into evidence in any civil action against a nursing home licensed under this Article, 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 may testify in any civil action as to any evidence or other matters produced or presented during the meetings or proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Notwithstanding the foregoing:

(1) Information, documents, or records otherwise available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, shall not be not immune from discovery or use in a civil action merely because they were presented during meetings or

proceedings of the advisory committee. A member of the advisory committee or a person who testifies before the committee may testify in a civil action but cannot be asked about that person's testimony before the committee or any opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to that which is reasonably necessary and relevant to the standards review organizations' determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under this subsection, and the standards review organization shall keep the information confidential subject to this subsection.

(3) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to that which is reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection, and the Department shall keep the information confidential subject to this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to that which is reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection, and the occupational licensing board shall keep the information confidential subject to this subsection.

(f) Duties. – The advisory committee shall do the following:

(1) Assess the nursing home's pharmaceutical management system, including, prescribing, distribution, and administration policies,

procedures, and practices and shall identify areas at high risk for medication-related errors.

(2) Review the nursing home's pharmaceutical management goals and respond accordingly to ensure that these goals are being met.

(3) Review, investigate, and respond to nursing home incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.

(4) Identify goals and recommendations for the implementation of best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.

(5) Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system within the nursing home of actual and potential medication-related errors.

(6) Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the North Carolina Nursing Practice Act.

(7) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures as to which patients may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, 131E-128.4, or 131E-128.5.

"**§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.**

(a) Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this subsection. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee and shall:

(1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.

(2) Increase prescription legibility.

(3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.

(4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.

(5) To the extent practicable, implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.

(6) Educate facility staff engaged in medication administration activities on similar-sounding drug names.

(7) Implement a system to accurately identify recipients before any drug is administered.

(8) Implement policies and procedures designed to improve accuracy in medication administration and in documentation by properly authorized individuals, in accordance with prescribed orders and stop order policies.

(9) Implement policies and procedures for the self-administration of medication.

(10) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.

(11) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

"**§ 131E-128.3. Staff orientation on medication error prevention.**

(a) The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

(1) General information relevant to the administration of medications including terminology, procedures, and routes of medication administration, and potential side effects and adverse reactions.

(2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.

(3) The facility's policy and procedures regarding its medication administration system.

(4) How to assist patients with safe and accurate self-administration, where appropriate.

(5) Identifying and reporting actual and potential medication-related errors.

"**§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.**

(a) The consultant pharmacist shall conduct a drug regimen review for actual and potential drug therapy problems and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

(1) Drug therapy which may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.

(2) Monitoring for potential adverse effects.

(3) Allergies.
(4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
(5) Contraindications and precautions.
(6) Potential therapeutic duplication.
(7) Over-extended length of treatment of certain drugs typically prescribed for a short period of time.
(8) Beer's listed drugs which are potentially inappropriate for use by elderly persons.
(9) Under treatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
(10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record including the medication administration records and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The pharmacist consultant shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety.

"**§ 131E-128.5. Medication-related error reports.**

(a) The Secretary of Health and Human Services shall contract with a public or private entity to develop and implement a Medication Error Quality Initiative. The Initiative would provide for, among other things, receipt and analysis by the contracting entity of annual reports from each nursing home on the nursing home's medication-related errors. The report submitted by the nursing home shall not contain information

that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The report shall include the following:

(1) The total number of medication-related errors for the preceding year.

(2) A listing of the types of medication-related errors, the number of medication-related errors, the root cause analysis of each error, and the staff level involved.

(3) A listing of the types of injury caused and the number of injuries occurring.

(4) Types of liability claims filed based on an adverse incident or reportable injury.

(b) The contracting entity shall provide for analysis of the medication-related error reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1, and contractor shall keep the information confidential subject to that section."

SECTION 2. This act becomes effective January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 1016
PROPOSED COMMITTEE SUBSTITUTE S1016-PCS40038-SW-31

Short Title: Nursing Home/Medication Errors. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING NURSING HOMES TO ESTABLISH A MEDICATION MANAGEMENT ADVISORY COMMITTEE AND SPECIFYING THE DUTIES OF THE COMMITTEE, AND TO REQUIRE NURSING HOMES TO DO CERTAIN THINGS PERTAINING TO THE REDUCTION OF MEDICATION-RELATED ERRORS TO INCREASE PATIENT SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new sections to read:

"**§ 131E-128.1. Nursing home medication management advisory committee.**

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

(1) 'Advisory committee' means a medication management committee established under this section to advise the quality assurance committee.

(2) 'Medication-related error' means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(3) 'Nursing home' means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.

(4) 'Potential medication-related error' means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.

(5) 'Quality assurance committee' means a quality assurance committee established in accordance with federal and State regulations to identify issues with respect to which quality assessment and assurance activities are necessary and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes in identifying medication-related errors, evaluate the causes of those errors, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

(1) The director of nursing.

(2) The consultant pharmacist.

(3) A physician designated by the nursing home administrator.

(4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The Director of Nursing or Staff Development Coordinator shall chair the advisory committee. The nursing home administrator shall ensure that a record is maintained of each meeting.

(e) Confidentiality. – The meetings or proceedings of the advisory committee, the records and materials it produces and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and G.S. 131E-128.5 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, shall be confidential and not considered public records within the meaning of G.S. 132-1, "Public records defined". The meetings or proceedings and records and materials also shall not be subject to discovery or introduction into evidence in any civil action against a nursing home licensed under this Article, 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 may testify in any civil action as to any evidence or other matters produced or presented during the meetings or proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Notwithstanding the foregoing:

(1) Information, documents, or records otherwise available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, shall not be immune from discovery or used in a civil action merely because they were presented during meetings or proceedings of

the advisory committee. A member of the advisory committee or a person who testifies before the committee may testify in a civil action but cannot be asked about that person's testimony before the committee or any opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to that which is reasonably necessary and relevant to the standards review organizations' determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under this subsection, and the standards review organization shall keep the information confidential subject to this subsection.

(3) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to that which is reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection, and the Department shall keep the information confidential subject to this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to that which is reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection, and the occupational licensing board shall keep the information confidential subject to this subsection.

(f) Duties. – The advisory committee shall do the following:

(1) Assess the nursing home's pharmaceutical management system, including prescribing, distribution, administration policies, procedures,

and practices and identify areas at high risk for medication-related errors.

(2) Review the nursing home's pharmaceutical management goals and respond accordingly to ensure that these goals are being met.

(3) Review, investigate, and respond to nursing home incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.

(4) Identify goals and recommendations for the implementation of best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.

(5) Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system within the nursing home of actual and potential medication-related errors.

(6) Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the North Carolina Nursing Practice Act.

(7) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures as to which patients may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, 131E-128.4, or 131E-128.5.

"**§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.**

(a) Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this subsection. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee and shall:

(1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.

(2) Increase prescription legibility.

(3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.

(4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.

(5) To the extent practicable, implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.

(6) Educate facility staff engaged in medication administration activities on similar-sounding drug names.

(7) Implement a system to accurately identify recipients before any drug is administered.

(8) Implement policies and procedures designed to improve accuracy in medication administration and in documentation by properly authorized individuals, in accordance with prescribed orders and stop order policies.

(9) Implement policies and procedures for the self-administration of medication.

(10) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.

(11) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

"**§ 131E-128.3. Staff orientation on medication error prevention.**

The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

(1) General information relevant to the administration of medications including terminology, procedures, and routes of medication administration, potential side effects and adverse reactions.

(2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.

(3) The facility's policy and procedures regarding its medication administration system.

(4) How to assist patients with safe and accurate self-administration, where appropriate.

(5) Identifying and reporting actual and potential medication-related errors.

"**§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.**

(a) The consultant pharmacist shall conduct a drug regimen review for actual and potential drug therapy problems and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

(1) Drug therapy which may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.

(2) Monitoring for potential adverse effects.

(3) Allergies.
(4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
(5) Contraindications and precautions.
(6) Potential therapeutic duplication.
(7) Over-extended length of treatment of certain drugs typically prescribed for a short period of time.
(8) Beer's listed drugs which are potentially inappropriate for use by elderly persons.
(9) Under treatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
(10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record including the medication administration records and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The pharmacist consultant shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety.

"**§ 131E-128.5. Medication-related error reports.**

(a) The Secretary of Health and Human Services shall contract with a public or private entity to develop and implement a Medication Error Quality Initiative. The Initiative would provide for, among other things, receipt and analysis by the contracting entity of annual reports from each nursing home on the nursing home's medication-related errors. The report submitted by the nursing home shall not contain information

that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The report shall include the following:

(1) The total number of medication-related errors for the preceding year.

(2) A listing of the types of medication-related errors, the number of medication-related errors, the root cause analysis of each error, and the staff level involved.

(3) A listing of the types of injury caused and the number of injuries occurring.

(4) Types of liability claims filed based on an adverse incident or reportable injury.

(b) The contracting entity shall provide for analysis of the medication-related error reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor retains its confidentiality and is not subject to discovery or use in any civil actions as provided under G.S. 131E-128.1, and the contractor shall keep the information confidential subject to that section."

SECTION 2. The Department shall use available grants and federal funds to implement G.S. 131E-182.5 as enacted in this act.

SECTION 3. This act becomes effective January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

S 1

SENATE BILL 582*

Short Title:	Public Schools/Healthy Kids.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health & Human Resources.	

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ENACT THE HEALTHY KIDS IN SCHOOLS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. This act is effective when it becomes law.

SENATE BILL 582:
Establish Commission on Childhood Obesity.

BILL ANALYSIS

Committee:	Senate Health & Human Services	**Introduced by:**	Sen. Purcell
Date:	April 30, 2003	**Summary by:**	Sara Kamprath
Version:	PCS for First Edition S582-CSRJ-18 [v.4]		Committee Analyst

SUMMARY: ***Senate Bill 582 creates the 27-member Commission on Childhood Obesity. The Commission shall various issues relating to childhood obesity and may make recommendations to change any law, rule or policy in order to lower obesity rates in the State. The final written report shall be made by Friday, May 7, 2004. The Commission shall terminate upon filing its final report. No new State funds shall be used for the Commission. The bill becomes effective when it becomes law.***

BILL ANALYSIS: There is created a 27-member Commission on Childhood Obesity. The members include legislators, the Superintendent of Public Instruction or his designee, and various members appointed by the Governor, the Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Health and Wellness Trust Fund Commission. The specific qualifications of the 27 members are spelled out in Section 2 of the bill. The chair of the Commission shall be the member appointed by the chair of the Health and Wellness Trust Fund Commission. The appointing authority that made the original appointment shall fill any vacancy on the Commission. The members of the Commission shall be paid the appropriate per diem, subsistence and travel allowances.

The study shall examine the causes of obesity in North Carolina's children, the socio-economic issues associated with childhood obesity, how the State should deal with childhood obesity and the steps that should be taken to prevent obesity in North Carolina.

The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Program.
(2) Physical education in public schools.
(3) Physical activities in public schools.
(4) Healthy and nutritional behavior by North Carolina students and when possible their families.

The Commission shall submit a final written report with its findings and recommendations to the Joint Legislative Health Care Oversight Committee, the Joint Legislative Education Oversight Committee and the Health and Wellness Trust Fund Commission by Friday, May 7, 2004. The Commission shall terminate when the final report is filed.

No new State funds shall be used for the Commission but only federal funds, private funds and existing State funds.

S582-SMRJ-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 582*
PROPOSED COMMITTEE SUBSTITUTE S582-CSRJ-18 [v.4]

4/29/2003 8:43:17 PM

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70 percent chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the U.S. is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications.

SECTION 1. There is established the Commission on Childhood Obesity.

SECTION 2. The Commission on Childhood Obesity shall be composed of 27 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund appointed by the chair of the Health and Wellness Trust Fund.

(3) Two parents of public school children and one public high school student appointed by the Governor after receiving recommendations from the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) Two members of a local board of education appointed by the Governor, after receiving recommendations from the North Carolina School Boards Association.

(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(9) One at-large member appointed by the Governor.

(10) Five members appointed by the President Pro Tempore of the Senate. In making these appointments the President Pro Tempore shall appoint the following:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One psychiatrist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the Speaker of the House of Representatives. In making these appointments the Speaker of the House of Representatives shall appoint the following:

a. One public school physical education specialist.
b. One representative from the More-At-Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school administrator.

Professional associations representing teachers, school administrators, and dentists may recommend appointees to the Speaker of the House.

(12) One representative of the vending machine industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving

recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socio-economic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; North Carolina Department of Public Instruction, Child Nutrition Services; BeActive North Carolina; Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The study shall include the following:

(1) The causes of obesity in North Carolina's children.

(2) The socio-economic issues associated with childhood obesity.

(3) How the State should deal with childhood obesity.

(4) The steps that should be taken to prevent obesity in North Carolina.

SECTION 5. The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Program.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and when possible their families.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004. The final report may contain a summary of recommendations for changes to any law, rule and policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, G.S. 138-5, and G.S. 138-6, as appropriate.

SECTION 8. Federal funds, private funds, and existing State funds may be used to support the Commission. No new State funds shall be used to support the Commission.

SECTION 9. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 582*
PROPOSED COMMITTEE SUBSTITUTE S582-PCS85230-RJ-18

Short Title: Establish Commission on Childhood Obesity. (Public)

Sponsors:

Referred to:

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMMISSION ON CHILDHOOD OBESITY.

Whereas, the four leading causes of death in North Carolina are stroke, heart disease, cancer, and diabetes, all of which are associated with overweight and obesity; and

Whereas, the prevalence of obesity has doubled in children and tripled in adolescents in the last two decades, bringing with it increased risk for future disease, as well as pediatric diagnoses of sleep apnea, orthopedic problems, psychological stress, and type 2 diabetes (formerly termed adult onset diabetes as it was rarely seen in persons under 30); and

Whereas, overweight teens have a 70% chance of becoming overweight or obese adults, making the next generation likely to have more adults with chronic diseases related to obesity at earlier ages than past generations; and

Whereas, the cost attributed to obesity and associated chronic diseases in the United States is more than $100 billion and these costs are spiraling upward; and

Whereas, children and adolescents are not meeting the recommendations of the Dietary Guidelines for Americans, including fruits and vegetables, but are consuming increasing amounts of foods high in fat and sugar; and

Whereas, standards were adopted in 1995 for meals served in the National School Lunch and School Breakfast Programs, but no standards exist for foods and beverages served a la carte in the cafeteria or in other venues during the school day; and

Whereas, regular physical activity substantially reduces the risk of dying of coronary heart disease and decreases the risk for stroke, colon cancer, diabetes, and high blood pressure. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. There is established the Commission on Childhood Obesity.

SECTION 2. The Commission on Childhood Obesity shall be composed of 27 members who have knowledge and interest in reversing the epidemic of childhood obesity and taking steps to prevent obesity. The members shall be appointed as follows:

(1) The Superintendent of Public Instruction or his or her designee.

(2) One member of the Health and Wellness Trust Fund appointed by the chair of the Health and Wellness Trust Fund.

(3) Two parents of public school children and one public high school student appointed by the Governor after receiving recommendations from the North Carolina State Parent Teacher Association.

(4) Two members of the Senate appointed by the President Pro Tempore of the Senate.

(5) Two members of the House of Representatives appointed by the Speaker of the House of Representatives.

(6) Two members of a local board of education appointed by the Governor, after receiving recommendations from the North Carolina School Boards Association.

(7) One public school child nutrition director appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(8) One public school nutrition education specialist appointed by the Governor, after receiving recommendations from the Superintendent of Public Instruction.

(9) One at-large member appointed by the Governor.

(10) Five members appointed by the President Pro Tempore of the Senate. In making these appointments, the President Pro Tempore shall appoint the following:

a. One public school health education teacher.
b. One representative from the Smart Start Program.
c. One pediatrician.
d. One psychiatrist, specializing in obesity.
e. One school administrator.

Professional associations representing teachers, school administrators, and the medical community may recommend appointees to the President Pro Tempore of the Senate.

(11) Five members appointed by the Speaker of the House of Representatives. In making these appointments, the Speaker of the House of Representatives shall appoint the following:

a. One public school physical education specialist.
b. One representative from the More At Four Program.
c. One dentist.
d. One member of the research community addressing the obesity epidemic.
e. One school administrator.

Professional associations representing teachers, school administrators, and dentists may recommend appointees to the Speaker of the House of Representatives.

(12) One representative of the vending machine industry, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the North Carolina Citizens for Business and Industry.

(13) One nutritionist, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from professional associations.

(14) One economist, with expertise in the socioeconomic issues associated with obesity, who is appointed by the Health and Wellness Trust Fund Commission, after receiving recommendations from the research community.

Each of the following organizations or agencies may select a representative from its organization or agency to advise the Commission. These members shall provide information to the Commission about the obesity epidemic in North Carolina: North Carolina Department of Health and Human Services, Division of Public Health; North Carolina Department of Public Instruction, Child Nutrition Services; Be Active North Carolina, Inc., Prevention Partners; American Cancer Society; American Heart Association; Action for Healthy Kids NC; Healthy Weight Initiative; and the Office of the Governor.

SECTION 3. The member of the Health and Wellness Trust Fund Commission appointed by the chair of the Health and Wellness Trust Fund Commission shall serve as the chair of the Commission. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4. The study shall include the following:

(1) The causes of obesity in North Carolina's children.

(2) The socioeconomic issues associated with childhood obesity.

(3) How the State should deal with childhood obesity.

(4) The steps that should be taken to prevent obesity in North Carolina.

SECTION 5. The Commission shall make recommendations that include the following:

(1) Nutritional guidelines for food served in public schools outside of the National School Lunch and School Breakfast Programs.

(2) Physical education in public schools.

(3) Physical activities in public schools.

(4) Healthy and nutritional behavior by North Carolina students and, when possible, their families.

The Commission is encouraged to explore different settings for its recommendations, including families, schools/child care, communities, health care, media/communication/social marketing, and surveillance/research.

SECTION 6. The Commission shall submit a final written report of its findings and recommendations to the Joint Legislative Health Care Oversight

Committee, the Joint Legislative Education Oversight Committee, and the Health and Wellness Trust Fund Commission no later than Friday, May 7, 2004. The final report may contain a summary of recommendations for changes to any law, rule, and policy that would lower or eradicate the obesity rates in North Carolina and our schools. Upon filing its final report, the Commission shall terminate.

SECTION 7. Members of the Commission shall be paid per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, and 138-6, as appropriate.

SECTION 8. Federal funds, private funds, and existing State funds may be used to support the Commission. No new State funds shall be used to support the Commission.

SECTION 9. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 975

Short Title:	Accessible Electronic Info Act/Blind/Disab'd.	(Public)
Sponsors:	Senators Dorsett; Dannelly, Jenkins, Kinnaird, Lucas, Malone, Metcalf, Moore, and Purcell.	
Referred to:	Appropriations/Base Budget.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN ACCESSIBLE ELECTRONIC INFORMATION SERVICE FOR BLIND AND DISABLED PERSONS AND TO APPROPRIATE FUNDS FOR THE SERVICE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 62 of the General Statutes is amended by adding a new section to read:

"**§ 62-157A. Accessible Electronic Information Act.**

(a) Short Title. – This section shall be known and may be cited as the 'Accessible Electronic Information Act'.

(b) Legislative Findings. – The General Assembly finds and declares all of the following:

(1) Thousands of citizens in the State have disabilities, including blindness or visual impairment, that prevent them from using conventional print material.

(2) The State fulfills an important responsibility by providing books and magazines prepared in Braille, audio, and large-type formats made available to eligible blind and disabled persons.

(3) The technology, transcription methods, and means of distribution used for these materials are labor-intensive and cannot support rapid dissemination to individuals in rural and urban areas throughout the State.

(4) Lack of direct and prompt access to information included in newspapers, magazines, newsletters, schedules, announcements, or other time-sensitive materials limits literacy, participation, and educational opportunities for blind and disabled persons.

(5) This limitation can best be overcome through use of high-speed computer and telecommunications technology, combined with

customized software, that provides a practical and cost-effective means to convert electronic text-based information, including daily newspapers, into synthetic speech suitable for statewide distribution with modern telecommunications technology.

(6) Low-cost interstate telecommunications rates make distribution of electronic text-based information to eligible users both efficient and cost-effective for the State.

(7) Federal funds have been used to develop the technology and infrastructure needed for statewide toll-free access to daily newspapers and other timely information of local, State, and national interest through a service known as NFB-NEWSLINE®, providing an efficient and cost-effective means of reader registration, content acquisition, and interstate telecommunications support.

(8) Use of this accessible electronic information service will enhance the State's current efforts to meet the needs of blind and disabled citizens for access to information that is otherwise available in print, thereby reducing isolation and supporting full integration and equal access for these individuals.

(c) Definitions. – The following definitions apply in this section:

(1) Accessible electronic information service. – A service where news and other timely information, including newspapers, is provided to eligible individuals from a multistate service center, using high-speed computers and telecommunications technology for interstate acquisition of content and rapid distribution in a form appropriate for use by blind and disabled persons.

(2) Blind and disabled persons. – Those individuals who are eligible for library loan services through the Library of Congress and the State Library for the Blind and Physically Handicapped pursuant to 36 C.F.R. § 701.10(b).

(3) Director. – The Director of the Division of Services for the Blind in the Department of Health and Human Resources.

(4) Qualified entity. – An agency, instrumentality, or political subdivision of the State or a nonprofit organization that:

a. Provides interstate access for eligible persons to read daily newspapers producing audio editions by computer.

b. Provides a means of program administration or reader registration on the Internet.

(d) Administration of Service. – The Division of Services for the Blind shall administer the statewide accessible electronic information service, including its establishment, operation, and promotion. The Director of the Division of Services for the Blind shall enter into an agreement with a qualified entity to provide an accessible electronic information service for eligible blind and disabled persons. The Division of Services for the Blind shall plan for continuation of the service from year to year and make maximum use of federal and other funds available by obtaining grant or in-kind

support from appropriate programs and securing access to low-cost interstate rates for telecommunications by reimbursement or otherwise.

(e) Accessible Electronic Information Service Fund. – In order to support an accessible electronic information service for blind and disabled persons:

(1) The Commission shall require all local exchange telecommunications companies to impose a periodic surcharge on bills rendered to all local exchange telecommunications company subscribers.

(2) The Commission, in consultation with the Director of the Division of Services for the Blind, shall annually determine the amount of the surcharge based on the amount of funding necessary to support the accessible electronic information service.

(3) The amount of the surcharge may be computed as a portion of any other surcharge required under existing law. In no event shall the surcharge exceed any existing surcharge by more than one cent (1¢) each line each month.

(4) Local exchange telecommunications companies shall remit the amount received from the surcharge to the Director of the Division of Services for the Blind less any amounts allowed for administration in accordance with a schedule determined by the Commission in consultation with the Director of the Division of Services for the Blind.

(f) Power to Regulate. – The Commission shall have the same power to regulate the operation of the accessible electronic information service as it has to regulate any public utility subject to the provisions of this Chapter."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of seventy thousand dollars ($70,000) for the 2003-2004 fiscal year to be used by the Division of Services for the Blind to establish an accessible electronic information service for blind and disabled persons in this State.

SECTION 3. This act becomes effective July 1, 2003.

SENATE BILL 975:
Accessible Electronic Info Act/Blind/Disab'd

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Sen. Dorsett
Date:	April 30, 2003	**Summary by:**	Amy Compeau
Version:	S975-CSLU-6 [v.1]		Research Division Staff

SUMMARY: ***The PCS to SB 975 would require the Division of Services for the Blind (Division) to establish and administer a statewide accessible electronic information service for eligible blind and disabled persons. The PCS would direct the North Carolina Utilities Commission to require all local exchange telecommunications companies to impose a surcharge on subscribers to fund the statewide accessible electronic information service. The surcharge must be established in consultation with the Director of the Division of Services for the Blind and could be no more than $.01 (per line, per month) over any existing surcharge. The act would become effective when it becomes law.***

The PCS deletes the appropriation of $70,000 for 2003-2004 to the Department of Health and Human Services to establish the statewide accessible electronic information service that existed in the original bill.

CURRENT LAW: Chapter 62 of the General Statues regulates public utilities. The Utilities Commission is required to make, fix, establish or allow just and reasonable rates for all public utilities subject to its jurisdiction. Except for bus companies, motor carriers and certain water and sewer utilities, the Commission shall fix rates that are fair to both the public utilities and to the consumer.

BILL ANALYSIS:

Accessible Electronic Information Service

The PCS would create the Accessible Electronic Information Act in Article 7, Rates of Public Utilities, of Chapter 62 of the General Statutes. The Division would be required to administer, establish, operate, and promote the statewide accessible electronic information service. The act defines the accessible electronic information service to mean a service where news and timely information is provide to *eligible* individuals from a multistate service center, using high-speed computers and telecommunications technology in a form appropriate for use by blind and disabled persons. The act defines eligible blind and disabled persons to mean those individuals who are eligible for library loan services through the Library of Congress and the North Carolina Library for the Blind and Physically Handicapped pursuant to 36 C.F.R. § 701.10(b). The Director of the Division of Services for the Blind must enter into an agreement with a qualified entity to provide the accessible electronic information service for eligible blind and disabled persons. The qualified entity would be an agency, instrumentality, or political subdivision that: (1) provides interstate access for eligible persons to read daily newspapers producing audio editions by computer and (2) provides a means of program administration or reader registration on the Internet. The Division must plan for the continuation of the statewide accessible electronic information service from year to year and must make use of federal and other funds available by obtaining grant or in-kind support from appropriate programs, including the Telecommunications Relay Service.

Accessible Electronic Information Service Fund

The Utilities Commission would require all local exchange telecommunications companies to impose a periodic surcharge that may not exceed any existing surcharge by more than $0.01 per line per month.

The Utilities Commission must consult with the Director of the Division of Services for the Blind to determine the amount of the surcharge. The local exchange telecommunications companies must remit the amount received from the surcharge to the Director less any amounts allowed for administration in accordance with a schedule determined by the Utilities Commission in consultation with the Director.

BACKGROUND:

36 C.F.R. § 701.10(b) Loans of library materials for blind other physically handicapped persons

The Library of Congress' National Library Service for the Blind and Physically Handicapped provides books in Braille, on sound reproduction recordings, or in any other form, under regulations established by the Librarian of Congress. The National Library Service also provides and maintains reproducers for such sound reproduction recordings for the use of blind and other physically handicapped residents of the United States as well as U.S. Territories and Insular Possessions, the District of Columbia, and American citizens temporarily domiciled abroad. The following persons are eligible for this service:

1. Blind persons whose visual acuity, as determined by competent authority, is 20/200 or less in the better eye with correcting glasses, or whose widest diameter if visual field subtends an angular distance no greater than 20 degrees.
2. Persons whose visual disability, with correction and regardless of optical measurement, is certified by competent authority as preventing the reading of standard printed material.
3. Persons certified by competent authority as unable to read or unable to use standard printed material as a result of physical limitations.
4. Persons certified by competent authority as having a reading disability resulting from organic dysfunction and of sufficient severity to prevent their reading printed material in a normal manner.

G.S. 62-157 Telecommunications Relay Service

The General Assembly created a statewide telecommunications relay service for telephone services to provide access to public telecommunications services for hearing impaired or speech-impaired persons, including those who also have vision impairment. Under the law, the Utilities Commission must require local service providers to impose a monthly surcharge on all residential and business local exchange access facilities to fund the statewide telecommunications relay service. The local service provider must collect the surcharge from their customers and deposit the moneys collected with the State Treasurer, who must maintain the funds in an interest-bearing, nonreverting account. Revenues from this fund are available only to the Department of Health and Human Services to administer the statewide telecommunications relay service program.

NFB-NEWSLINE®

In the fall of 2000 Congress passed an appropriations bill to make NFB NEWSLINE® nationwide, and the President signed it into law. The NFB NEWSLINE® became available March 1, 2002.

Each state can arrange for at least two papers of local interest to be on the program. The National NFB NEWSLINE® Network provides seven national newspapers. The newspaper publishers send a file of the news to the National NFB NEWSLINE® Network in Baltimore, Maryland on a daily basis. Each newspaper is converted into speech in a few minutes, and then it can be read by telephone, via a toll-free number, by blind callers from any part of the country.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 975
PROPOSED COMMITTEE SUBSTITUTE S975-CSLU-6 [v.1]

4/29/2003 6:11:23 PM

Short Title: Accessible Electronic Info Act/Blind/Disab'd. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN ACCESSIBLE ELECTRONIC INFORMATION SERVICE FOR BLIND AND DISABLED PERSONS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 62 of the General Statutes is amended by adding a new section to read:

"**§ 62-157A. Accessible Electronic Information Act.**

(a) Short Title. – This section shall be known and may be cited as the 'Accessible Electronic Information Act'.

(b) Legislative Findings. – The General Assembly finds and declares all of the following:

(1) Thousands of citizens in the State have disabilities, including blindness or visual impairment, that prevent them from using conventional print material.

(2) The State fulfills an important responsibility by providing books and magazines prepared in Braille, audio, and large-type formats made available to eligible blind and disabled persons.

(3) The technology, transcription methods, and means of distribution used for these materials are labor-intensive and cannot support rapid dissemination to individuals in rural and urban areas throughout the State.

(4) Lack of direct and prompt access to information included in newspapers, magazines, newsletters, schedules, announcements, or other time-sensitive materials limits literacy, participation, and educational opportunities for blind and disabled persons.

(5) This limitation can best be overcome through use of high-speed computer and telecommunications technology, combined with customized software, that provides a practical and cost-effective means

to convert electronic text-based information, including daily newspapers, into synthetic speech suitable for statewide distribution with modern telecommunications technology.

(6) Low-cost interstate telecommunications rates make distribution of electronic text-based information to eligible users both efficient and cost-effective for the State.

(7) Federal funds have been used to develop the technology and infrastructure needed for statewide toll-free access to daily newspapers and other timely information of local, State, and national interest through a service known as NFB-NEWSLINE®, providing an efficient and cost-effective means of reader registration, content acquisition, and interstate telecommunications support.

(8) Use of this accessible electronic information service will enhance the State's current efforts to meet the needs of blind and disabled citizens for access to information that is otherwise available in print, thereby reducing isolation and supporting full integration and equal access for these individuals.

(c) Definitions. – The following definitions apply in this section:

(1) Accessible electronic information service. – A service where news and other timely information, including newspapers, is provided to eligible individuals from a multistate service center, using high-speed computers and telecommunications technology for interstate acquisition of content and rapid distribution in a form appropriate for use by blind and disabled persons.

(2) Director. – The Director of the Division of Services for the Blind in the Department of Health and Human Services.

(3) Eligible blind and disabled persons. – Those individuals who are eligible for library loan services through the Library of Congress and the North Carolina Library for the Blind and Physically Handicapped pursuant to 36 C.F.R. § 701.10(b).

(4) Qualified entity. – An agency, instrumentality, or political subdivision of the State or a nonprofit organization that:

a. Provides interstate access for eligible persons to read daily newspapers producing audio editions by computer.

b. Provides a means of program administration or reader registration on the Internet.

(d) Administration of Service. – The Division of Services for the Blind shall administer the statewide accessible electronic information service, including its establishment, operation, and promotion. The Director shall enter into an agreement with a qualified entity to provide an accessible electronic information service for eligible blind and disabled persons. The Division of Services for the Blind shall plan for continuation of the service from year to year and make maximum use of federal and other funds available by obtaining grant or in-kind support from appropriate programs, including the Telecommunications Relay Service under G.S. 62-157, and securing

access to low-cost interstate rates for telecommunications by reimbursement or otherwise.

(e) Accessible Electronic Information Service Fund. – In order to support an accessible electronic information service for blind and disabled persons:

(1) The Commission shall require all local exchange telecommunications companies to impose a periodic surcharge on bills rendered to all local exchange telecommunications company subscribers.

(2) The Commission, in consultation with the Director, shall annually determine the amount of the surcharge based on the amount of funding necessary to support the accessible electronic information service.

(3) The amount of the surcharge may be computed as a portion of any other surcharge required under existing law. In no event shall the surcharge exceed any existing surcharge by more than one cent (1¢) each line each month.

(4) Local exchange telecommunications companies shall remit the amount received from the surcharge to the Director less any amounts allowed for administration in accordance with a schedule determined by the Commission in consultation with the Director.

(f) Power to Regulate. – The Commission shall have the same power to regulate the operation of the accessible electronic information service as it has to regulate any public utility subject to the provisions of this Chapter."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 975
PROPOSED COMMITTEE SUBSTITUTE S975-PCS65288-LU-6

Short Title: Accessible Electronic Info Act/Blind/Disab'd. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN ACCESSIBLE ELECTRONIC INFORMATION SERVICE FOR BLIND AND DISABLED PERSONS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 62 of the General Statutes is amended by adding a new section to read:

"**§ 62-157A. Accessible Electronic Information Act.**

(a) Short Title. – This section shall be known and may be cited as the 'Accessible Electronic Information Act'.

(b) Legislative Findings. – The General Assembly finds and declares all of the following:

(1) Thousands of citizens in the State have disabilities, including blindness or visual impairment, that prevent them from using conventional print material.

(2) The State fulfills an important responsibility by providing books and magazines prepared in Braille, audio, and large-type formats made available to eligible blind and disabled persons.

(3) The technology, transcription methods, and means of distribution used for these materials are labor-intensive and cannot support rapid dissemination to individuals in rural and urban areas throughout the State.

(4) Lack of direct and prompt access to information included in newspapers, magazines, newsletters, schedules, announcements, or other time-sensitive materials limits literacy, participation, and educational opportunities for blind and disabled persons.

(5) This limitation can best be overcome through use of high-speed computer and telecommunications technology, combined with customized software, that provides a practical and cost-effective means

to convert electronic text-based information, including daily newspapers, into synthetic speech suitable for statewide distribution with modern telecommunications technology.

(6) Low-cost interstate telecommunications rates make distribution of electronic text-based information to eligible users both efficient and cost-effective for the State.

(7) Federal funds have been used to develop the technology and infrastructure needed for statewide toll-free access to daily newspapers and other timely information of local, State, and national interest through a service known as NFB-NEWSLINE®, providing an efficient and cost-effective means of reader registration, content acquisition, and interstate telecommunications support.

(8) Use of this accessible electronic information service will enhance the State's current efforts to meet the needs of blind and disabled citizens for access to information that is otherwise available in print, thereby reducing isolation and supporting full integration and equal access for these individuals.

(c) Definitions. – The following definitions apply in this section:

(1) Accessible electronic information service. – A service where news and other timely information, including newspapers, is provided to eligible individuals from a multistate service center, using high-speed computers and telecommunications technology for interstate acquisition of content and rapid distribution in a form appropriate for use by blind and disabled persons.

(2) Director. – The Director of the Division of Services for the Blind in the Department of Health and Human Services.

(3) Eligible blind and disabled persons. – Those individuals who are eligible for library loan services through the Library of Congress and the North Carolina Library for the Blind and Physically Handicapped pursuant to 36 C.F.R. § 701.10(b).

(4) Qualified entity. – An agency, instrumentality, or political subdivision of the State or a nonprofit organization that:

a. Provides interstate access for eligible persons to read daily newspapers producing audio editions by computer.

b. Provides a means of program administration or reader registration on the Internet.

(d) Administration of Service. – The Division of Services for the Blind shall administer the statewide accessible electronic information service, including its establishment, operation, and promotion. The Director shall enter into an agreement with a qualified entity to provide an accessible electronic information service for eligible blind and disabled persons. The Division of Services for the Blind shall plan for continuation of the service from year to year and make maximum use of federal and other funds available by obtaining grant or in-kind support from appropriate programs, including the Telecommunications Relay Service under G.S. 62-157, and securing

access to low-cost interstate rates for telecommunications by reimbursement or otherwise.

(e) Accessible Electronic Information Service Fund. – In order to support an accessible electronic information service for blind and disabled persons:

(1) The Commission shall require all local exchange telecommunications companies to impose a periodic surcharge on bills rendered to all local exchange telecommunications company subscribers.

(2) The Commission, in consultation with the Director, shall annually determine the amount of the surcharge based on the amount of funding necessary to support the accessible electronic information service.

(3) The amount of the surcharge may be computed as a portion of any other surcharge required under existing law. In no event shall the surcharge exceed any existing surcharge by more than one cent (1¢) each line each month.

(4) Local exchange telecommunications companies shall remit the amount received from the surcharge to the Director less any amounts allowed for administration in accordance with a schedule determined by the Commission in consultation with the Director.

(f) Power to Regulate. – The Commission shall have the same power to regulate the operation of the accessible electronic information service as it has to regulate any public utility subject to the provisions of this Chapter."

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

VISITOR REGISTRATION SHEET

Health and Human Resources — April 30, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Joyce	NCACC
John Cymus	NC State Grange
Mary Mustian	Poyner + Spruill
DAVID BARNES	Poyner + Spruill
Ken Melton	Alley Associates, Inc.
Butch Gunnells	NCSDA
Stacia McKenney	NCDNHS
Bob Lawyer	NCDHHS
[illegible]	[illegible]
Peter A. Yancy	FRLTC
Joanne Stevens	Nursing

VISITOR REGISTRATION SHEET

Health and Human Resources — **Name of Committee**

April 30, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Herman Struker	Nat'l Fed Blind of NC
Dixie Struker	Nat'l Fed Blind of NC
	NC DPJ
	NCSDA
	NCSDA
	NCSDA
	WCHS
Tim Keatley	NC SDA
Andy Harris	NCSDA
	Public School Forum
	SBE

VISITOR REGISTRATION SHEET

Health and Human Resources — April 30, 2003

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Laura R Kennedy	NCSDA
Jackie Sheppard	DHHS
Gary Ray	Nat'l Fed Blind of NC

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE

Wednesday, May 7, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

- **HB 1177,** ***Volunteer M.D.s at Therapeutic Rec. Camps***

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 7, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, May 7, 2003 in Room 544 of the Legislative Office Building. Nine members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Representative Insko, who had planned to present H.B. 80 and H.B. 883 at this meeting was called out of town unexpectedly and will present these bills to the committee at a later date.

Senator Purcell called on Senator Tillman to explain H.B. 1177, *Volunteer M.D.s at Therapeutic Rec. Camps* to the committee. Senator Lucas asked who would oversee the volunteer physicians that come as to the validity of their licenses. Senator Tillman said that their credentials would be inspected before coming to the camp. Ms. Sandra Alley, research staff, said that each of these centers has a medical director. Senator Purcell called on Steve Keene, General Counsel for the North Carolina Medical Society. He said that the Medical Board would look to the centers' medical director for certification of the volunteer doctors. Senator Malone agreed that there should be some kind of screening process. Senator Tillman agreed, stating that the licensed medical director for the center be the one to establish certification of the volunteer doctors and that they should be in good standing. Senator Lucas asked staff to draw up an amendment to this effect. It was read to the committee and passed. Senator Forrester asked if the allowed time for volunteering could be extended to up to 30 days a year instead of 14 and asked for an amendment for this. Ms. Jessup read the requested amendment to the committee. Senator Lucas moved for adoption of the amendment, and it passed. Senator Dannelly moved that the amendments be rolled into a proposed committee substitute. The motion passed and the amended bill received a favorable report from the committee.

The meeting adjourned at 11:18 A.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, May 08, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B. **1177** Volunteer M.D.s at Therapeutic Rec. Camps.

Draft Number:	PCS30314
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1177
PROPOSED COMMITTEE SUBSTITUTE H1177-PCS30314-SP-6

Short Title: Volunteer M.D.s at Therapeutic Rec. Camps. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PHYSICIANS IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE MAY PRACTICE MEDICINE OR SURGERY AT A CAMP FOR THERAPEUTIC RECREATION FOR INDIVIDUALS WITH CHRONIC ILLNESSES UNDER CERTAIN RESTRICTED CONDITIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

...

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.

b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.

c. The physician receives no compensation for the services.

d. The physician provides those services within this State for no more than 30 days per calendar year.

e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 1177

Senate Health & Human Resources Committee Substitute Adopted 5/8/03

Short Title: Volunteer M.D.s at Therapeutic Rec. Camps. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT PHYSICIANS IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE MAY PRACTICE MEDICINE OR SURGERY AT A CAMP FOR THERAPEUTIC RECREATION FOR INDIVIDUALS WITH CHRONIC ILLNESSES UNDER CERTAIN RESTRICTED CONDITIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

...

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.

b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.

c. The physician receives no compensation for the services.

d. The physician provides those services within this State for no more than 30 days per calendar year.

e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

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

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 1177 DATE May 7, 2003

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) Lucas
(Sen.))

moves to amend the bill on page 1, line s 15-16

( ) WHICH CHANGES THE TITLE

by rewriting the lines to read:

"a. The physician provides documentation ~~satisfactory~~ to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.";

and on page 1, line 22, by deleting "14" and substituting "30".

SIGNED Jeanne Lucas

ADOPTED ✓ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

VISITOR REGISTRATION SHEET

HEALTH & HUMAN RESOURCES — **May 7, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marion Smith	citizen
John Bowdish	AstraZeneca
Lori B. Wilson	NCALTCF.
Cam Cover	BPMHL
Stella McKenney	HHS
STEVE KEENE	NCMS.
Amy Jo Horne	NCMS
Camille Steel	KCLH
Ken Melton	Alley Associates

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 14, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

BILL NO.	SHORT TITLE	SPONSOR
• HB 80	Reports to Mental Health Oversight Comm.	Rep. Insko
• HB 461	Interpreter Licensure Effective Date	Rep. Alexander
• HB 462	Health Insurance/Marriage & Family Therapists	Rep. Alexander
• HB 907	Deaf/Hard of Hearing Advisory Council	Rep. Alexander
• HB 883	MH Reform Waiver	Rep. Insko

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 14, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11 A.M. on Wednesday, May 14, 2003 in Room 544 of the Legislative Office Building. Eleven members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator William Purcell, Co-Chair, welcomed the committee members and introduced the pages.

The summary for HB 80 was not available at the beginning of the meeting so Senator Bingham, Co-Chair moved to HB 461. Rep. Alexander was recognized to explain her bill, HB 461, ***Interpreter Licenser Effective Date.*** The bill makes changes for setting the time of the appointment and organization of the licensing board for the deaf interpreter. Many times when bills are passed of this type all the appointments are not made. This bill moves the date so these appointments can be made to this board. Senator Lucus moved for a favorable report. The motion carried.

Rep. Alexander had another bill and was recognized to explain, HB 462, ***Health Insurance/Marriage & Family Therapist***, which will add the marriage and family therapist to the list of professional services for which an individual has the right to chose their provider. This is not a mandate. They are many others who are listed in this particular section of the statutes. This is for private providers. The marriage and family therapist are already in the state health plan. Senator Forrester, asked about a fiscal note because it will allow the therapist to receive direct from third party reimbursements. He wanted to know if there will be any impact on the state health plan stating it may even save the state money. Rep. Alexander stated there is a fiscal note (attached) but it shows no impact. This bill allows people to choose their provider, they might choose to go to a marriage and family therapist or they might choose to go to a clinical social worker that goes into that grouping, so it would not add any fiscal impact. It is just giving them a choice. Senator Forrester asked what was the reason they could form a professional corporation in the last section of the bill on page five. Rep. Alexander stated it is just adding them to the statutes with other professions to allow them that they may participate as a professional corporation. Mr. John Kerr who represents the NC Associations for Marriage and Family Therapy stated that one of the reasons is the expanding system of mental health reform the state is currently undergoing. A lot of the providers are moving from community mental health centers into private practice to serve the state population. It will be of great benefits to all providers for them to be able to join in corporations with those other providers to form a team of services, which is what the state would like to see. Senator Queen asked if the state is interested in the family counselors being a part of this team approach. Mr. Kerr stated he has received an informal report that the state does intend to directly enroll marriage and family therapist as well as other licensed mental health providers within the mental health reform that is undergoing right now. Senator Queen asked what kind of professional certifications and training do these providers have in this category. Rep. Alexander stated that they have voluntary certification. It became available to them in 1979. They have a license to engage in the practice of marriage and family therapist since 1995. They specialize in the diagnosis of a wide variety of mental and emotional disorders and they are licensed by the state already. Senator Purcell stated they are Master level people. Mr. John Kerr stated they have to be master level in Marriage and Family Therapist or a related field. The state of NC has two institutes that provide that graduate program, one at Appalachian State University and one at East Carolina University. NC is the only state to have two. Following that degree they have to undergo 1500 hours of direct face to

face clinical supervision before they can be licensed. Senator Dannley moved for a favorable report. The motion carried.

Senator Bingham, Co-Chair, shifted back to HB 80, which was first on the agenda. Rep. Insko was recognized to explain HB 80, ***Reports to Mental Health Oversight Committee***. This bill would require the department to included the legislative oversight committee on the mental health developmental disabilities and substance abuse and any of the reports they make to other legislative committees. Senator Dannelly moved for a favorable report. Senator Lucus seconded. The motion carried.

Senator Bingham, Co-Chair recognized Rep. Alexander to explain HB 907, ***Deaf/Hard of Hearing advisory Council***. Senator Purcell sent forth an amendment and asked staff, Amy Compeau to explain. The amendment specifies for the staggered terms of the four new governor appointees. Currently. the second edition says they will commence their office when the bill becomes effective. This amendment sets a specific date that they will commence on July 1. Senator Kinnaird moved to pass the amendment. The motion carried. Rep. Alexander stated she has had the opportunity to serve on The Deaf and Hard of Hearing Advisory Council and this bill clarifies some of the duties as they have changed over the years. As an example it clarifies that the council would make recommendation to the secretary for cost effective provision coordination improvement of services and require the council to create public awareness of the specific needs of the deaf and hard of hearing. It also would change the membership and the appointing authority and the member qualifications and increase the membership of the council from 25 members to 27 members. It would have 2 additional members appointed by the Governor, one recommended by the NC Chapter of Self Help for the Hard of Hearing, a member recommended by the NC Black Deaf Advocates, a member recommended by the President of the NC Deaf Blind Associates, and a member recommended by a local Education Agency. Senator Dannelly moved to roll the amendment into a Proposed Senate Committee Substitute, unfavorable original bill, favorable as to Committee Substituted. The motion carried

Senator Stan Bingham, Co-Chair recognized Rep. Insko to explain the final bill, HB 883, ***Mental Health Reform Waiver***. It was held until last in order for Senator Metcalf, the Senate Co Sponsor to come from another committee meeting. Rep. Insko explained that this bill expands the category of professionals who can complete level one involuntary commitments to mental health institutions. This will not change the process. The process of an involuntary commitment includes two steps, level one step is done in the community and currently psychiatrist and Ph.D. physiologist and physicians can do that first level commitment. Then a person is taken to a state institution and the level two commitment review is done. The level two assessment has to be done by a psychiatrist and there is a psychiatrist in all four state institutions who do that. Until a person passes that second assessment they are not actually committed. Sometimes the psychiatrist in our state institution will say the person does not qualify for admission and they will be sent back to the local community. We now have in the mental health reform 39 area programs. One of those programs, Smoky Mountain Area Program, has seven counties. In those seven counties there are four psychiatrist. The Smoky Mountain Area Program has had a contract with one of their hospitals to help out with first level commitments and its capacity to do this is limited due to the increase in the people that go to the emergency room. This area program is proposing that they would have a crisis intervention center that they would create with several beds. Anyone that would need a first level commitment would be brought to this crisis intervention center. In order to staff it 24 hours per day 7 days per week they request that they be able to use masters level clinical social workers, masters level psychiatric nurses or masters level substance abuse councilors to help staff the crisis intervention center in off hours.

Senator Metcalf sent forth an amendment stating it would allow the secretary to increase it from one area program to no more than five programs. And the department shall assure the staff performing the duties are trained and privileged to perform the functions as identified in the waver. Senator Allran asked how many Ph.D. Psychologist are there in the Smoky Mountain

Area. Rep. Insko stated that the language in the bill says qualified psychologist, which is clinical psychologist. Sally Cameron with the NC Psychologist Association, was recognized. She does not have an exact number but she can think of more than five off the top of her head. Senator Queen recommended the amendment. The amendment passed unanimously.

Senator Purcell sent forth another amendment and asked Dianna Jessup, Research Staff, to explain. On page 2 line 22 there is an evaluation that the secretary has to perform on the effectiveness quality and efficient of the services under the waver and this just adds report to the legislative oversight committee on the results of the evaluation. Senator Dannelly made a motion for a favorable report to the second amendment. The motion carried.

Senator Allran wanted to know if someone is held against their will in the judicial process because they are accused of some criminal activity then they will be held in a jail cell and if someone is held against their will because of mental or medical problem then you usually have a doctor involved in the process so in this case you are holding them against their will without the judicial process involved in it directly or not a medical professional, where are these people being held and how exactly does that work. Terra Larson, Deputy Director, for the division of Mental Health was recognized to answer the question. Ms. Larson explained this process does not alter the due process rights of any individual who in that process of committing what you are referring to and what this is referring to is an involuntary commitment process. There is still the involvement of obtaining the appropriate legal documentation in order to do pick up orders or to hold that person for an assessment to be done to move forward to the next process. Right now that due process allows for that person to remain in the supervision of law enforcement in emergency rooms or mental facilities and it is all within the due process. This legislation allows for while that person is being held that the people who may perform the assessment to determine whether that person is dangerous to self or others can be done by another professional and it names those professionals. If that person through that process passes that threshold then it goes to the second level commitment, who is a psychologist or physician at the next level Also in this bill even under the conditions of a social worker or nurse, a physician must also be available if required so that if there is a medical issue that person must be available for face to face evaluation or telephone consultation. Specifically in the Smoky Mountain Area about 70% of the first level evaluations are being done in the emergency room at the hospital, not by psychiatrist but by physicians. This is trying to look at a quality not only about what's happening in that persons life in that restrictive situation but it is to look at what's happening with the other resources like tying up the emergency room and law enforcement who have to wait. The person would be held at the crisis intervention center until they are transferred to the state institution. Senator Purcell stated that other professionals are assessing patients right now and the doctors have to sign it and agree with it. Senator Hartsell made the motion for a favorable report as amended to roll into a committee substitute. The motion carried.

The meeting adjourned at 12:00

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 14, 2003

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

FAVORABLE

H.B.(CS #1) **80** Reports to Mental Health Oversight Comm.
Sequential Referral: None
Recommended Referral: None

H.B. **461** Interpreter Licensure Effective Date.
Sequential Referral: None
Recommended Referral: None

H.B. **462** Health Insurance/Marriage & Family Therapists.
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) **907** Deaf/Hard of Hearing Advisory Council.
Draft Number: PCS30333
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 4

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, May 15, 2003

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **883** MH Reform Waiver.

Draft Number:	PCS 45141
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 80

Committee Substitute Favorable 3/12/03

Short Title: Reports to Mental Health Oversight Comm. (Public)

Sponsors:

Referred to:

February 25, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT CERTAIN REPORTS BE MADE TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-5 reads as rewritten:

"**§ 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~~ Joint Legislative Oversight Committee 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 2. G.S. 131D-42 reads as rewritten:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee 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 3. G.S. 131D-10.6(10) reads as rewritten:

"**§ 131D-10.6. Powers and duties of the Department.**

In addition to other powers and duties prescribed by law, the Department shall exercise the following powers and duties:

...

(10) Report annually on October 1 to the ~~Legislative Study Commission~~ Joint Legislative Oversight Committee 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 4. Article 27 of Chapter 120 of the General Statutes is amended by adding the following new section to read:

"**§ 120-243. Reports to Committee.**

Whenever the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is required by law to report to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 80:
Reports to Mental Health Oversight Comm.

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Rep. Insko
Date:	May 14, 2003	**Summary by:**	Amy Compeau
Version:	Second Edition		Research Division Staff

SUMMARY: ***The second edition to House Bill 80 would require the Secretary and the Department of Health and Human Services (DHHS) to submit annual reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (Committee) regarding the use of physical restraints and seclusion in mental health, adult care home, and residential child-care facilities. Current law specifies the submission of these reports to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission). House Bill 80 would also require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS, to send to the cochairs of the Committee, a copy of all required reports made to the General Assembly. The act is effective when it becomes law.***

CURRENT LAW:

Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services

The Commission was established in 1996 with the enactment of HB 53, The Appropriations Act of 1996 (Sec. 24.8 of Chapter 18 of the 1995 session laws, extra session, 1996). It has not been repealed. The purpose of the 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 membership of this committee is comprised of members of the General Assembly and representatives of the public.

Restraints in Facilities

During the 2000 Regular Session of the 1999 General Assembly, the legislature enacted HB 1520, (S.L. 2000-129) to amend the law pertaining to the use of physical restraints and seclusion in mental health facilities, residential child care facilities, and adult care homes. The legislation requires several reports by the Secretary and by the DHHS describing the extent of compliance of facilities with State and federal laws governing the use of physical restraints or seclusion and the number of deaths that may be associated with their use. The reports are to be made annually to the Commission. No reports have been submitted.

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

The Committee was established one month prior to the enactment of HB 1520 during the 2000 Regular Session via the enactment of HB 1519 (S.L. 2000-83). The purpose of the Committee is to "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 is directed to "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." The membership of the Committee consists entirely of members of the General Assembly.

BILL ANALYSIS: House Bill 80 requires the reports referenced in S.L. 2000-129 to be submitted to the Committee instead of the Commission. The bill does not delete the reporting requirements nor does it repeal the statutes creating the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services. The bill also requires the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to transmit a copy of any report the Division is required to submit to the General Assembly or to any of its permanent committees or subcommittees on matters affecting mental health, developmental disabilities, and substance abuse services to the cochairs of the Committee.

BACKGROUND:

The North Carolina Administrative Code defines the below terms in 10-14P.0102 under Title 10 DHHS, Chapter 10-14 Mental Health:

"**Physical Restraint**" means the application or use of any manual method of restraint that restricts freedom of movement; or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. Holding a client in a therapeutic hold or other manner that restricts his or her movement constitutes manual restrains for that client. Mechanical devices may restrain a client to a bed or chair, or may be used as ambulatory restraints. Examples of mechanical devices include cuffs, ankle straps, sheets or restraining shirts, arm splints, posey mittens, and helmets. Excluded from this definition of physical restraint are physical guidance, gentle physical prompting techniques, escorting a client who is walking; soft ties used solely to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices; and prosthetic devices or assistive technology which are designed and used to increase client adaptive skills. Escorting means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a client to walk to a safe location.

"**Seclusion**" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.

Linda Attarian, former staff attorney, contributed significantly to this summary.

H80-SMRP-002

H 1

HOUSE BILL 461

Short Title:	Interpreter Licensure Effective Date.	(Public)
Sponsors:	Representative Alexander.	
Referred to:	Judiciary I.	

March 13, 2003

A BILL TO BE ENTITLED

AN ACT TO DELAY THE EFFECTIVE DATE OF THE INTERPRETER AND TRANSLITERATOR LICENSURE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90D-5(b) reads as rewritten:

"(b) Composition and Terms. – The Board shall consist of nine members who shall serve staggered terms. The initial Board members shall be selected on or before ~~January 1, 2003,~~ July 1, 2003, as follows:

(1) A member of the North Carolina Association of the Deaf (NCAD) who is deaf and familiar with the interpreting process. This member shall be appointed by the Governor and serve for a term of two years.

(2) An interpreter who is a member of the North Carolina Registry of Interpreters for the Deaf, Inc., (NCRID) with five years experience in a community setting and who is licensed to practice as an interpreter or transliterator under this Chapter. This member shall be appointed by the Governor and serve for a term of three years.

(3) An employee of the North Carolina Department of Health and Human Services. This member shall be appointed by the Governor, upon recommendation of the Secretary of the Department, and serve a term of three years.

(4) An interpreter or transliterator for deaf-blind individuals who is licensed to practice as an interpreter or transliterator under this Chapter or a deaf-blind individual who is a member of the North Carolina Deaf-Blind Association and who has knowledge of the interpreting process. This member shall be appointed by the General Assembly, upon recommendation of the President Pro Tempore of the Senate, and serve for a term of three years.

(5) A cued speech or oral transliterator licensed to practice as an interpreter or transliterator under this Chapter. This member shall be

appointed by the General Assembly, upon recommendation of the President Pro Tempore of the Senate, and serve for a term of two years.

(6) A member of Self Help for Hard of Hearing (SHHH) with knowledge of the interpreting process and deafness. This member shall be appointed by the General Assembly, upon recommendation of the President Pro Tempore of the Senate, and serve for a term of three years.

(7) An interpreter who is a member of the North Carolina Registry of Interpreters for the Deaf, Inc., (NCRID) with five years experience in an educational setting in grades K-12 and who is licensed to practice as an interpreter or transliterator under this Chapter. This member shall be appointed by the General Assembly, upon recommendation of the Speaker of the House of Representatives, and serve for a term of two years.

(8) A faculty member of an Interpreter Training Program (ITP), an Interpreter Preparation Program (IPP), or a qualified or professional certified instructor of the American Sign Language Teachers Association (ASLTA). This member shall be appointed by the General Assembly, upon recommendation of the Speaker of the House of Representatives, and serve for a term of two years.

(9) A public member. This member shall be appointed by the General Assembly, upon recommendation of the Speaker of the House of Representatives, and serve a term of two years. For purposes of this section, a public member shall not be licensed under this Chapter or have an immediate family member who is deaf or hard-of-hearing.

Upon the expiration of the terms of the initial Board members, each member shall be appointed for a term of three years and shall serve until a successor is appointed and qualified. No member may serve more than two consecutive full terms."

SECTION 2. Section 7 of S.L. 2002-182 reads as rewritten:

"**SECTION 7.** A person practicing interpreter or transliterator services on the effective date of this act who submits the following evidence to the Board and pays the required fee ~~within 18 months of the effective date of this act,~~ on or before December 31, 2004, shall be licensed without having to satisfy the requirements of subdivision (a)(3) of G.S. 90D-7 as enacted in Section 1 of this act:

(1) Evidence that the person meets the qualifications in subdivisions (a)(1) and (a)(2) of G.S. 90D-7.

(2) Evidence that the person has been actively engaged as an interpreter or transliterator in this State for at least 200 hours for each of the two years immediately preceding the effective date of this act. The evidence must be verified in writing by sources approved by the Board.

(3) Two letters of recommendation from sources approved by the Board.

(4) A fee of seventy-five dollars ($75.00) for the registration. This fee shall be in lieu of the fee for a license authorized in G.S. 90D-10 of the act.

A person who obtains a license by meeting the requirements of this section must comply with the continuing education requirements set by the Board. Any practicing person who does not register with the Board ~~within 18 months of the effective date of this act~~ on or before December 31, 2004, shall be required to complete all requirements prescribed by the Board and to otherwise comply with the provisions of Chapter 90D, enacted by Section 1 of this act."

SECTION 3. Section 10 of S.L. 2002-182 reads as rewritten:

"**SECTION 10.** G.S. 90D-5 and G.S. 90D-6, as enacted in Section 1 of this act, and Sections 7, 8, 9, and 10 of this act are effective when the act becomes law. The remainder of the act becomes effective ~~July 1, 2003.~~January 1, 2004."

SECTION 4. Notwithstanding G.S. 150B-21.1(a)(1), the North Carolina Interpreter and Transliterator Licensing Board may adopt temporary rules to implement S.L. 2002-182 until January 1, 2004.

SECTION 5. Sections 1 through 3 of this act become effective October 31, 2002. The remainder of this act is effective when it becomes law.

HB 461:
Interpreter Licensure Effective Date.

BILL ANALYSIS

Committee:	Senate Health & Human Services	**Introduced by:**	Rep. Alexander
Date:	May 14, 2003	**Summary by:**	Sara Kamprath*
Version:	First Edition		Committee Analyst

SUMMARY: ***The bill would make changes to the implementation of the Interpreter and Transliterator Licensure Act, extending the time for the appointment and organization of the licensing board.***

BILL ANALYSIS:

- **Section 1:** Delays the final deadline for the appointment of the North Carolina Interpreter and Transliterator Licensing Board (" the Board") until July 1, 2003.
- **Section 2:** Allows grandfathering to continue from the time of the appointment of the Board until December 31, 2004.
- **Section 3:** Delays the remainder of the effective dates to January 1, 2004.
- **Section 4:** Extends the temporary rulemaking authority until January 1, 2004.
- **Section 5:** Keeps the original October 31, 2002, effective date for the Board and the grandfathering, to cover the possibility of the Board being appointed prior to the enactment of this bill.

BACKGROUND:

Under Chapter 8B of the General Statutes, a deaf person must be provided a qualified interpreter in judicial, legislative, or administrative proceedings. Beginning July 1, 2003, a "qualified interpreter" will be a person who is licensed by the North Carolina Interpreter and Transliterator Licensing Board. Session Law 2002-182 created the North Carolina Interpreter and Transliterator Licensing Board and basic licensing requirements. The Board was granted the authority to adopt rules, temporary and permanent, to enforce the act. The Board was to be appointed by January 1st of this year and was given 18 months to be up and running. The Board has not yet been appointed.

Similar legislation granting additional time for appointment and organization was enacted for the Locksmith Licensing Board in 2002 in Session Law 2002-63.

EFFECTIVE DATE: Sections 1 through 3 of the bill become effective October 31, 2002 and the remainder of the bill becomes effective when it becomes law.

H461-SMRJ-002

* R. Erika Churchill and Mary Shuping contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 462*

Short Title:	Health Insurance/Marriage & Family Therapists.	(Public)
Sponsors:	Representatives Alexander, G. Wilson (Primary Sponsors); Wainwright and Warner.	
Referred to:	Children, Youth and Families.	

March 13, 2003

A BILL TO BE ENTITLED

AN ACT TO INCLUDE DULY LICENSED MARRIAGE AND FAMILY THERAPISTS UNDER THE INSURANCE 'FREEDOM OF CHOICE' LAW AND UNDER THE PROFESSIONAL CORPORATIONS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.**

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that 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 licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute,

subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) 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 licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, 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, or a provider listed in this subsection, 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; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter 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" is 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 licensed clinical social worker" is a "licensed clinical social worker" as defined in G.S. 90B-3(2) and licensed by the North Carolina Social Work Certification and Licensure Board 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.

(c2) For purposes of this section, a "duly certified substance abuse professional" is a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(c4) For purposes of this section, a "duly licensed marriage and family therapist" is a person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C 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, unless these plan requirements apply to all providers for that service.

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.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (a1) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in subsection (a1) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (a1) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected.

(h) Nothing in this section shall be construed as expanding the scope of practice of any duly licensed physician or provider listed in subsection (a1) of this section."

SECTION 2. G.S. 90-270.48B is repealed.

SECTION 3. G.S. 55B-2(6) reads as rewritten:

"(6) The term "professional service" means any type of personal or professional service of the public which requires as a condition

precedent to the rendering of such service the obtaining of a license from a licensing board as herein defined, and pursuant to the following provisions of the General Statutes: Chapter 83A, "Architects"; Chapter 84, "Attorneys-at-Law"; Chapter 93, "Public Accountants"; and the following Articles in Chapter 90: Article 1, "Practice of Medicine," Article 2, "Dentistry," Article 6, "Optometry," Article 7, "Osteopathy," Article 8, "Chiropractic," Article 9A, "Nursing Practice Act," with regard to registered nurses, Article 11, "Veterinarians," Article 12A, "Podiatrists," Article 18A, "Practicing Psychologists," Article 18C, "Marriage and Family Therapy Licensure," Article 18D, "Occupational Therapy," and Article 24, "Licensed Professional ~~Counselors," of Chapter 90; Counselors~~"; Chapter 89C, "Engineering and Land Surveying"; Chapter 89A, "Landscape Architects"; Chapter 90B, "Social Worker Certification and Licensure Act" with regard to Certified [Licensed] Clinical Social Workers as defined by G.S. 90B-3; Chapter 89E, "Geologists"; Chapter 89B, "Foresters"; and Chapter 89F, "North Carolina Soil Scientist Licensing Act."

SECTION 4. G.S. 55B-14(c)(4) reads as rewritten:

"**§ 55B-14. Types of professional services.**

...

(c) A professional corporation may also be formed by and between or among:

...

(4) A physician, or a licensed psychologist, or both, and a certified clinical specialist in psychiatric and mental health nursing, a licensed clinical social worker, a licensed marriage and family therapist, 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 5. Sections 1 and 2 of this act become effective October 1, 2003, and apply to claims for payment or reimbursement for services rendered on or after that date. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: HB 462 (1st Edition)

SHORT TITLE: Health Insurance/Marriage and Family

SPONSOR(S): Representatives Alexander and G. Wilson

FISCAL IMPACT

Yes ( ) **No (X)** **No Estimate Available ( )**

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES					
EXPENDITURES	No Fiscal Impact				
POSITIONS: (cumulative)					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Insurance, Secretary of State

EFFECTIVE DATE: Section 1 is effective October 1, 2003, and applies to claims for payment or reimbursement for services rendered on or after October 1, 2003. Sections 3 & 4 are effective when the bill becomes law.

BILL SUMMARY (adopted from the Research Division's bill summary):
The bill would add licensed marriage and family therapists to the list of professional services for which an individual has the right to choose the provider, allow those therapists to receive direct third party reimbursements, and recognize those therapists under the Professional Corporations Act.

ASSUMPTIONS AND METHODOLOGY:
Generally (adopted from the bill summary prepared by the Research Division):

Marriage and family therapists are licensed professionals under Article 18C of Chapter 90. That article specifically provides that direct third party reimbursements to licensed marriage and family therapists are not required. G.S. § 90-2700.48B. Marriage and family therapists are not part of the insurance "Freedom of Choice" statutes, allowing individuals to select the provider of their choosing and still receive payment under that individual's health benefit plan as provided for in G.S. § 58-50-30.

Section 1 would add the services of a duly licensed marriage and family therapist to those services, which an individual has the right to select the provider of their choice and still be, covered notwithstanding their health insurance plan or policy statements.

Section 2 would allow for the requirement of direct third party reimbursements to licensed marriage and family therapists.

Sections 3 and 4 would add the profession of licensed marriage and family therapists to those professions that may participate in a professional corporation.

Department of Insurance:
The Department of Insurance is responsible for monitoring and regulating the covered services and terms of coverage offered by insurance companies. This responsibility is carried out through the Department's Life and Health Division's review and approval of insurance companies' policy forms to ensure that they are in compliance with applicable laws and regulations. The Department believes that the review and enforcement activity necessary to ensure that providers are complying with the requirements to (1) include licensed marriage and family therapists to those services for which an individual has the right to select the provider and still be covered by their health insurance plan and (2) allow for the direct third party reimbursement to licensed marriage and family therapist fall within the Department's current form review authority. Thus, the Department does not anticipate that this bill will have any fiscal impact on them.

Secretary of State:
The Corporations Division within the Department of the Secretary of State is responsible for the examination, custody and maintenance of the legal documents filed by more than 400,000 corporations, limited partnerships and limited liability companies. This bill would allow licensed marriage and family therapist to form a professional corporation. To form such a corporation would require registration with the Secretary of State. Currently, these therapists are allowed to form other types of business entities that also require registration with the Secretary of State. Thus, allowing them to form professional corporations would only change the nature of the filings. Fiscal Research believes, therefore, that this bill would not have a fiscal impact on the Secretary of State.

SOURCES OF DATA: Fiscal Research Division

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910
PREPARED BY: Marilyn Chism

Marilyn Chism

APPROVED BY: James D. Johnson, Director Fiscal Research Division

James D. Johnson

DATE: April 30, 2003

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 907*

Committee Substitute Favorable 4/29/03

Short Title: Deaf/Hard of Hearing Advisory Council. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND THE HARD OF HEARING, TO INCREASE THE MEMBERS ON THE COUNCIL, AND TO CHANGE THE APPOINTING AUTHORITY FOR TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.31 reads as rewritten:

"**§ 143B-216.31. Council for the Deaf and the Hard of Hearing – creation and duties.**

There is hereby created the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services. The Council shall have duties including the following:

(1) To make recommendations to the Secretary of the Department of Health and Human Services ~~regarding improvement of human services to the deaf and the hard of hearing;~~for cost-effective provision, coordination, and improvement of services;

(2) To ~~study ways to promote public understanding of the problems of the deaf and the hard of hearing and to consider the need for new State programs concerning deafness;~~create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind and to consider the need for new State programs concerning the deaf, hard of hearing, and deaf-blind;

(3) To advise the Secretary of the Department of Health and Human Services ~~in the preparation of a plan describing the quality, extent and scope of services provided or to be provided, to deaf and hard of hearing persons in this State;~~during planning and implementation of services being provided to North Carolina citizens who are deaf, hard of hearing, or deaf-blind with respect to the quality, extent, and scope of those services;

(4) To ~~study any State programs that provide educational services for deaf and hard of hearing persons and to advise the Secretary of the Department of Health and Human Services and the Superintendent of Public Instruction concerning coordination of these programs to prevent duplication of services; and~~advise the Secretary of the Department of Health and Human Services and the Superintendent of the Department of Public Instruction regarding planning, implementation, and cost-effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind; and

(5) To ~~advise and make recommendations to the Secretary of the Department of Health and Human Services upon any matter as requested by the Secretary.~~respond to the request of the Secretary of the Department of Health and Human Services for advice or recommendations pertaining to any matter affecting deaf, hard of hearing, or deaf-blind citizens of North Carolina."

SECTION 2. G.S. 143B-216.32 reads as rewritten:

"**§ 143B-216.32. Council for the Deaf and the Hard of Hearing – membership; quorum; compensation.**

(a) The Council for the Deaf and the Hard of Hearing shall consist of ~~25~~ 27 members. ~~Fifteen~~ Nineteen members shall be members appointed by the Governor. Three members appointed by the Governor shall be persons who are deaf and three members shall be persons who are hard of hearing. One appointment shall be an educator who trains deaf education teachers and one appointment shall be an audiologist licensed under Article 22 of Chapter 90 of the General Statutes. Three appointments shall be parents of deaf or hard of hearing children including one parent of a student in a residential school; one parent of a student in a preschool program; and one parent of a student in a mainstream education program, with at least one parent coming from each region of the North Carolina schools for the deaf regions. One member appointed by the Governor shall be recommended by the President of the North Carolina Association of the Deaf; one member shall be recommended by the President of the North Carolina Deaf-Blind Associates; one member shall be recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH); one member shall be recommended by the North Carolina Black Deaf Advocates (NCBDA); one member shall be recommended by the President of the North Carolina Pediatric Society; one member shall be recommended by the President of the North Carolina Registry of Interpreters for the Deaf; one member shall be recommended by a local education agency; and one member shall be ~~nominated~~ recommended by the Superintendent of Public Instruction. Two members shall be appointed from the House of Representatives by the Speaker of the House of Representatives and two members shall be appointed from the Senate by the President Pro Tempore of the Senate. The Secretary of Health and Human Services shall appoint ~~six~~ four members as follows: one from the Division of Vocational Rehabilitation, one from the Division of Aging, one from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and one

from the Division of Social ~~Services, one from a North Carolina Chapter of SHHH (Self Help for the Hard of Hearing), and one from SPEAK (Statewide Parents' Education and Advocacy for Kids).~~Services.

(b) The terms of the initial members of the Council shall commence July 1, 1989. In his initial appointments, the Governor shall designate four members who shall serve terms of five years, four who shall serve terms of four years, four who shall serve terms of three years, and three who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member ~~appointed by the Governor~~ shall serve more than two successive ~~terms.~~terms unless the member is an employee of the Department of Health and Human Services or the Department of Public Instruction representing his or her agency as a specialist in the field of service.

Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

(c) The chairman of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chairman shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chairman. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 3. Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, when the term of the member appointed by the Secretary of Health and Human Services who is a representative from the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Chapter of Self Help for the Hard of Hearing to serve a four-year term to commence when this act becomes effective. When the term of the member appointed by the Secretary of Health and Human Services who is a representative from Statewide Parents' Education and Advocacy for Kids (SPEAK) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Black Deaf Advocates (NCBDA) to serve a four-year term to commence when this act becomes effective.

Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, the member appointed by the Governor as recommended by the President of the North Carolina Deaf-Blind Associates shall be appointed for a four-year term to commence when this act becomes effective and the member appointed by the Governor as recommended by a local education agency shall be appointed for a four-year term to commence when this act becomes effective. Members described in this section shall serve for the terms for which they were appointed and until their successors are appointed and qualified.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 907*

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

H907-ARP-6 [v.3]

Date 5-14 ,2003

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Senator Purcell

moves to amend the bill on page 3, line 30, by deleting "when this act becomes effective." and substituting: "July 1, 2003.";

on page 3, lines 34-35, by deleting "when this act becomes effective." and substituting "July 1, 2003.";

on page 3, lines 38-39, by deleting "when this act becomes effective" and substituting "July 1, 2003"; and

on page 3, line 41, by deleting "when this act becomes effective." and substituting "July 1, 2003.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 907*

Committee Substitute Favorable 4/29/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H907-PCS30333-RP-11

Short Title: Deaf/Hard of Hearing Advisory Council. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO THE COUNCIL FOR THE DEAF AND THE HARD OF HEARING, TO INCREASE THE MEMBERS ON THE COUNCIL, AND TO CHANGE THE APPOINTING AUTHORITY FOR TWO OF THE MEMBERS APPOINTED TO THE COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.31 reads as rewritten:

"**§ 143B-216.31. Council for the Deaf and the Hard of Hearing – creation and duties.**

There is hereby created the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services. The Council shall have duties including the following:

(1) To make recommendations to the Secretary of the Department of Health and Human Services ~~regarding improvement of human services to the deaf and the hard of hearing;~~for cost-effective provision, coordination, and improvement of services;

(2) To ~~study ways to promote public understanding of the problems of the deaf and the hard of hearing and to consider the need for new State programs concerning deafness;~~create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind and to consider the need for new State programs concerning the deaf, hard of hearing, and deaf-blind;

(3) To advise the Secretary of the Department of Health and Human Services ~~in the preparation of a plan describing the quality, extent and scope of services provided or to be provided, to deaf and hard of hearing persons in this State;~~during planning and implementation of services being provided to North Carolina citizens who are deaf, hard

of hearing, or deaf-blind with respect to the quality, extent, and scope of those services;

(4) To ~~study any State programs that provide educational services for deaf and hard of hearing persons and to advise the Secretary of the Department of Health and Human Services and the Superintendent of Public Instruction concerning coordination of these programs to prevent duplication of services; and~~advise the Secretary of the Department of Health and Human Services and the Superintendent of the Department of Public Instruction regarding planning, implementation, and cost-effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind; and

(5) To ~~advise and make recommendations to the Secretary of the Department of Health and Human Services upon any matter as requested by the Secretary.~~respond to the request of the Secretary of the Department of Health and Human Services for advice or recommendations pertaining to any matter affecting deaf, hard of hearing, or deaf-blind citizens of North Carolina."

SECTION 2. G.S. 143B-216.32 reads as rewritten:

"**§ 143B-216.32. Council for the Deaf and the Hard of Hearing – membership; quorum; compensation.**

(a) The Council for the Deaf and the Hard of Hearing shall consist of ~~25~~ 27 members. ~~Fifteen~~ Nineteen members shall be members appointed by the Governor. Three members appointed by the Governor shall be persons who are deaf and three members shall be persons who are hard of hearing. One appointment shall be an educator who trains deaf education teachers and one appointment shall be an audiologist licensed under Article 22 of Chapter 90 of the General Statutes. Three appointments shall be parents of deaf or hard of hearing children including one parent of a student in a residential school; one parent of a student in a preschool program; and one parent of a student in a mainstream education program, with at least one parent coming from each region of the North Carolina schools for the deaf regions. One member appointed by the Governor shall be recommended by the President of the North Carolina Association of the Deaf; one member shall be recommended by the President of the North Carolina Deaf-Blind Associates; one member shall be recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH); one member shall be recommended by the North Carolina Black Deaf Advocates (NCBDA); one member shall be recommended by the President of the North Carolina Pediatric Society; one member shall be recommended by the President of the North Carolina Registry of Interpreters for the Deaf; one member shall be recommended by a local education agency; and one member shall be ~~nominated~~ recommended by the Superintendent of Public Instruction. Two members shall be appointed from the House of Representatives by the Speaker of the House of Representatives and two members shall be appointed from the Senate by the President Pro Tempore of the Senate. The Secretary of Health and Human Services shall appoint ~~six~~ four members as follows: one from the Division

of Vocational Rehabilitation, one from the Division of Aging, one from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and one from the Division of Social ~~Services, one from a North Carolina Chapter of SHHH (Self Help for the Hard of Hearing), and one from SPEAK (Statewide Parents' Education and Advocacy for Kids).~~Services.

(b) The terms of the initial members of the Council shall commence July 1, 1989. In his initial appointments, the Governor shall designate four members who shall serve terms of five years, four who shall serve terms of four years, four who shall serve terms of three years, and three who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member ~~appointed by the Governor~~ shall serve more than two successive ~~terms.~~terms unless the member is an employee of the Department of Health and Human Services or the Department of Public Instruction representing his or her agency as a specialist in the field of service.

Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

(c) The chairman of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chairman shall hold this office for not more than four years.

(d) The Council shall meet quarterly and at other times at the call of the chairman. A majority of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 3. Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, when the term of the member appointed by the Secretary of Health and Human Services who is a representative from the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Chapter of Self Help for the Hard of Hearing to serve a four-year term to commence July 1, 2003. When the term of the member appointed by the Secretary of Health and Human Services who is a representative from Statewide Parents' Education and Advocacy for Kids (SPEAK) expires, the Governor shall appoint one member upon the recommendation of the North Carolina Black Deaf Advocates (NCBDA) to serve a four-year term to commence July 1, 2003.

Pursuant to G.S. 143B-216.32(a), as enacted in Section 2 of this act, the member appointed by the Governor as recommended by the President of the North Carolina Deaf-Blind Associates shall be appointed for a four-year term to commence July 1, 2003 and the member appointed by the Governor as recommended by a local education agency shall be appointed for a four-year term to commence July 1, 2003. Members described in this section shall serve for the terms for which they were appointed and until their successors are appointed and qualified.

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

HOUSE BILL 907:
Deaf/Hard of Hearing Advisory Council

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Rep. Alexander
Date:	May 14, 2003	**Summary by:**	Amy Compeau
Version:	Second Edition		Research Division Staff

SUMMARY: ***The second edition to House Bill 907 would amend the laws relating to the Council for the Deaf and the Hard of Hearing (Council), increase the members on the Council from 25 to 27, and change the appointing authority and membership composition of two of the members appointed to the Council. The act would become effective when it becomes law.***

CURRENT LAW: S.L. 1989-533 established the Council for the Deaf and the Hard of Hearing of the Department of Health and Human Services (DHHS). The North Carolina General Assembly established the Council to advise the Secretary of DHHS (Secretary) on matters pertaining to the services for deaf and hard of hearing people.

BILL ANALYSIS:

Section 1 would amend the duties of the Council as follows:

1. The bill clarifies that the Council would make recommendations to the Secretary for cost-effective provision, coordination, and improvement of services. (Current law requires the Council to make recommendations regarding improvement of human services to the deaf and hard of hearing.)
2. The bill would require the Council to create public awareness of the specific needs and abilities of people who are deaf, hard of hearing, or deaf-blind. (Current law requires the Council to study ways to promote public understanding.)
3. The bill would specify that the Council would advise the Secretary during planning and implementation of services being provided with respect to the quality, extent, and scope of those services. (Current law requires the Council to advise the Secretary in the preparation of a plan for services to be provided).
4. The Council would advise the Secretary and the Superintendent of the Department of Public Instruction regarding planning, implementation and cost effective coordination of State programs providing educational services for persons who are deaf, hard of hearing, or deaf-blind. (This part of the bill makes clarifying changes to the law.)
5. The Council would respond to the Secretary's requests for advice or recommendations pertaining to any matter affecting deaf, hard of hearing or deaf-blind citizens. (Current law requires the Council to advise the Secretary on any matter requested.)

Section 2 would change the membership, appointing authority, member qualification and term limits of certain Council members. HB 907 would increase membership to the Council from 25 to 27 members. The two additional members would be appointed by the Governor as follows: (1) member recommended by the North Carolina Chapter of Self Help for the Hard of Hearing (SHHH) and (1) member recommended by the North Carolina Black Deaf Advocates (NCBDA). The bill would allow the Governor to appoint two additional members to the Council as follows: (1) member recommended by the

President of the North Carolina Deaf-Blind Associates and (1) member recommended by a local education agency. The bill, then, would increase the number of Council members appointed by the Governor from 15 members to 19 members.

HB 907 would decrease the number of Council members appointed by the Secretary from 6 members to 4 members.

HB 907 would clarify that no member could serve more than two successive terms unless the member is an employee of DHHS or the Department of Public Instruction representing the agency as a specialist in the field of service.

Section 3 would specify staggered terms for the four new appointees of the Governor to the Council.

Section 4 would make the act effective when it becomes law.

BACKGROUND: According to Division of Services for the Deaf and Hard of Hearing, DHHS, the bill is deleting an outdated reference in statute, and it adds representation to the Council from two organizations. Current law requires the Secretary to appoint a member from Statewide Parents' Education and Advocacy for Kids (SPEAK). This organization no longer exists so the bill would delete the reference. The bill would add members to the Council based upon the recommendation of NCBDA and of the President of the North Carolina Deaf-Blind Associates.

Current law requires the Secretary to appoint two members to the Council from organizations representing the deaf community. These members do not have term limits. Current law requires the Governor to appoint members to the Council from organizations representing the deaf community as well as other individuals who are deaf or hard of hearing or who are parents of deaf or hard of hearing children. The members appointed by the Governor cannot serve more than two consecutive four-year terms. The bill would require the Governor to make all appointments from the deaf and hard of hearing community to the Council so they would have the same term limits.

H907-SMRP-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 3

HOUSE BILL 883

Committee Substitute Favorable 4/28/03
Committee Substitute #2 Favorable 4/29/03

Short Title: MH Reform Waiver. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(5) The Secretary may grant a waiver under this section only to one local management entity located in the western part of the State that has been designated a phase-one entity as of July 1, 2003.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver.

(8) The local management entity shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 883 DATE 5/14/03

S. B. No. _____ Amendment No. 2
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Purcell
Sen.)

moves to amend the bill on page 2, line 24

( ) WHICH CHANGES THE TITLE

by adding at the end of the line the following:

"The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before ~~December~~ July 1, 2006.".

SIGNED William K. Purcell

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 883

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

H883-ASW-19 [v.2]

Date _____,2003

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Senator Metcalf

moves to amend the bill on page 2, lines 29-31, by rewriting the lines to read:

"(5) The Secretary may grant a waiver under this section to up to five local management entities that have been designated as phase-one entities as of July 1, 2003.";

and on page 2, line 39, by adding at the end of the line the following:

1 to 5

- "The Department shall involve stakeholders, including but not limited to the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 883:
MH Reform Waiver

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Rep. Insko
		Summary by:	Dianna Jessup Committee Counsel
Date:	May 13, 2003		
Version:	Third Edition		

SUMMARY: House Bill 883 would authorize the Secretary of the Department of Health and Human Services (Secretary) to permit a phase one, mental health local management entity (LME) to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examination of individuals in involuntary commitment proceedings. Any waiver could only be in effect for a period not to exceed three years. The proposed bill would not expand the scope of practice for licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists. The act would become effective July 1, 2003 and expire July 1, 2006.

CURRENT LAW:

Mental Health Reform: As enacted by the 2001 General Assembly, S.L. 2001-437 (HB 381), amended the mental health statutes to provide counties an alternative to establishing area authorities to ensure the provision of public mental health, developmentally disabled and substance abuse (MH/DD/SA) services to consumers. Counties were authorized to withdraw from existing area authorities and to ensure the delivery of public MH/DD/SA services through a single county program or jointly with one or more counties through a joint agency established pursuant to the terms of an interlocal agreement. (County programs and area authorities are known as LMEs). By October 1, 2002, each county was to have sent a letter of intent to the Secretary indicating the intent of the county or counties to provide services through an existing area authority or through a county program. The bill provided for phased-in implementation of reform, requiring the Secretary to certify the business plans of one-third of the area authorities and county programs by July 1, 2003; two-thirds of the area authorities and county programs by January 1, 2004; and complete certification of all area authorities and county programs by July 1, 2004.

Under the new governance scheme, LMEs are required to develop "business plans" to guide the management and delivery of services. These business plans are required to be submitted to the Secretary for review and certification. The business plans must provide a description of how core administrative functions will be carried out, including planning to ensure the provision of services, ensuring available, qualified providers to deliver services, service management, financial management, service monitoring, evaluation, and collaboration with other local service systems. Business plans are effective for three State fiscal years.

Involuntary Commitment: Anyone who has knowledge that a person who is mentally ill or is a substance abuser and who is dangerous to self or dangerous to others may petition the court for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist. If the clerk finds reasonable grounds to believe that the facts in the petition are true and the respondent is dangerous to self or others, the clerk may order the respondent to be taken into custody for an initial examination by a physician or eligible psychologist. If the physician or eligible psychologist recommends inpatient commitment, then a *physician* is required to perform an examination of the respondent within 24 hours after the respondent is admitted into a facility. This examination would determine whether the respondent

is mentally ill or a substance abuser and is dangerous to self or dangerous to others, and the results of this examination are considered by the court at the hearing to determine whether the respondent should be involuntarily committed.

Licensed Clinical Social Workers (LCSW): Social workers are licensed under Chapter 90B of the General Statutes. G.S. 90B-3 defines a LCSW to mean 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. According to the North Carolina Social Work Board website, the requirements for becoming a LCSW include the following:

- A Masters in Social Work (MSW), a Doctorate in Social Work (DSW), or a Doctorate in Philosophy (PhD) from a Council on Social Work Education (CSWE) accredited program.
- 3,000 hours of paid employment accumulated in no less than two years nor more than six years. (No more than 1500 hours accumulated in one year.)
- 100 hours of clinical supervision from a LCSW with a graduate degree in Social Work and two years of supervised clinical experience. Of these 100 hours at least 75 hours must have been individual supervision.
- Take and pass the American Association of Social Work Boards "Clinical level" examination.

Psychiatric Nurses: 10-3C.5202 of the NC Administrative Code defines a psychiatric nurse to mean an individual who is licensed to practice as a registered nurse in the State by the NC Board of Nursing; and has the following:

- A graduate degree from an accredited master's level program in psychiatric mental health nursing with two years of experience; or
- A master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing; or
- A baccalaureate degree in behavioral science with four years of supervised clinical experience in psychiatric mental health nursing.

According to the NC Board of Nursing, a masters level psychiatric nurse is an advanced practice registered nurse generally referred to as a psychiatric-mental health clinical nurse specialist. A masters level psychiatric nurse would be eligible for direct reimbursement of services.

Certified Clinical Addictions Specialists: G.S. 90-113.31 defines a certified clinical addictions specialist to be a person certified by the NC Substance Abuse Professional Certification Board to practice as a clinical addictions specialist in accordance with the provisions of Article 5C of the General Statutes. G.S. 90-113.40 requires the Board to issue a certificate certifying an applicant as a certified clinical addictions specialist if it meets certain requirements for a certified substance abuse counselor or a certified substance abuse prevention consultant and meets one of four sets of criteria specified in statute.

BILL ANALYSIS: The second edition for House Bill 883 would authorize the Secretary, upon request of a phase-one LME in the western part of the State, to waive temporarily the requirements of the involuntary commitment statutes regarding who can conduct the initial examination to permit LCSWs, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct the examination. In order to obtain this waiver, the LME must, as part of its business plan, describe how the

purpose of the statutory requirement would be better served by waiving the requirement, how the waiver will enable the LME to improve the delivery or management of services, how the services to be provided by the LCSWs, masters level psychiatric nurses, and masters level certified clinical addictions specialists are within the scope of practice for those professions, and how the health, safety, and welfare of persons will be protected. In order to approve the LME's request for the waiver, the Secretary must find that: (1) the request meets the requirements of the bill, (2) the request furthers the purposes of State policy, and MH/DD/SA services reform, (3) the request improves the delivery of MH/DD/SA services in the counties affected by the waiver and protects the health, safety, and welfare of individuals receiving these services, and (4) the duties and responsibilities performed by the LCSWs, masters level psychiatric nurses, or the masters level certified clinical addictions specialists are within the scope of practice for these professions. The Secretary shall evaluate the services and the protection of health, safety, and welfare under the waiver. A waiver could be in effect for a period not to exceed three years or the period, for which the business plan is approved, whichever is shorter. The LME would have to ensure that a physician is available at all times to provide back-up services and to include telephonic approval and face-to-face evaluation, if necessary.

The act would become effective July 1, 2003 and expire July 1, 2006.

Amy Compeau, Research Assistant, contributed to this summary.

H883-SMSW-003

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 883

Committee Substitute Favorable 4/28/03

Committee Substitute #2 Favorable 4/29/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H883-PCS45141-SW-38

Short Title: MH Reform Waiver. (Public)

Sponsors:

Referred to:

April 7, 2003

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES TO FURTHER MENTAL HEALTH REFORM EFFORTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of Health and Human Services may, upon request of a phase-one local management entity, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from a phase-one local management entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the local management entity shall be submitted as part of the entity's local business plan and shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the local management entity to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services on or before July 1, 2006.

(4) The waiver granted by the Secretary under this section shall be in effect for a period not to exceed three years, or the period for which the requesting local management entity's business plan is approved, whichever is shorter.

(5) The Secretary may grant a waiver under this section to up to five local management entities that have been designated as phase-one entities as of July 1, 2003.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The local management entity shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires July 1, 2006.

H883
MH Reform Waiver

Amendment to Add Licensed Professional Counselors to Provisions Authorizing Preliminary Commitment Evaluations

As presently drafted, H883 (MH Reform Waiver) would allow the Department of Health and Human Services to waive temporarily the requirements of North Carolina's involuntary commitment statutes to allow licensed clinical social workers, masters-level psychiatric nurses, or masters-level certified clinical additions specialists to conduct initial examinations for purposes of involuntary commitment. The North Carolina Association of Licensed Professional Counselors seeks to have licensed professional counselors included among the provider groups covered by the H883 waiver authority.

Licensed professional counselors are masters-level mental health clinicians with the same qualifications as the mental health providers already listed in H883. The exclusion of licensed professional counselors from H883 unfairly discriminates against licensed professional counselors as a provider class.

In recent years, the North Carolina General Assembly has acted to assure the recognition of licensed professional counselors as qualified providers of clinical mental health services. In 1993 the General Assembly created the North Carolina Board of Licensed Professional Counselors and authorized the licensure of licensed professional counselors as mental health professionals. In 2001, the Assembly directed North Carolina insurers to reimburse licensed professional counselors in the same manner as other masters-level mental health professionals, such as psychologists, clinical social workers, and psychiatric nurses. In 2002, the Assembly directed the North Carolina Division of Medical Assistance to eliminate discrimination in the state's Medicaid reimbursement coding system that treated professional licensed counselors unfairly.

The North Carolina Division of State Personnel has established position descriptions for licensed professional counselors that recognize their parity with other masters-level mental health providers. And earlier this year, the Division of Mental Health, Developmental Disability and Substance Abuse Services recommend that licensed professional counselors be made eligible for direct enrollment as in the State Medicaid Program.

H883 should be amended so as to harmonize it with these other recent actions of the General Assembly and the Department of Health and Human Services. A draft amendment for this purpose is attached.

For more information contact
Suzanne Walker, Licensed Professional Counselors Association of North Carolina
at (910) 322-1743, or by e-mail at Walkercssj@aol.com.

House Bill 883
MH Reform Waiver
Proposed Amendment

At page 1 line 15, and at page 2, line 32, insert the phrase "licensed professional counselor," after the phrase "social worker", and

At page 2 lines 19 and 36, insert the phrase "the licensed professional counselor" after the phrase "social worker".

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 14, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nancy R. Laitinen	Interpreters, Inc. Wake Forest, NC
Jennifer Allen	Edmisten + Webb
Chad Essick	Edmisten + Webb
Lu-Ann Cole	NCPA
Carol Lauder	EGHS
ANN LAZE	DUHS
Mr Ann Lore	Self
Paul D. Valeri	Hair Council
Sally Cameron	NC Psychological Assn.
Jennifer Sullivan	NASW-NC
Janet Schnizenbach	NC Council
Jon Carr	Jordan Price

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 14, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roz Sewitt	NC Child Care Coalition
BILL HALEY	JORDAN PRICE
Jean Ramsey	NCNP
Tasha Clary	YATO
Matt Osborne	AOC
[illegible]	NCAHP
BRIAN LEWIS	Planned Parenthood
Karen McDonald	DJJDP
[illegible]	[illegible]
Dean Kirkland	Fayetteville Academy (NC)
Spring Batstone	Parade Page, Carson, NC
Cynthia Tarchenson	GACPD

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 14, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gregory P. Gelinas	NC GACPD 2113 Cameron St Suite 218 Raleigh NC 27605
Leon M Killian	Moore Van Allen
Julie Allen	NC Statewatch
Rogers Bone	Bone McAllester

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 21, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- HB 253, *Continuing Care Ret./Tech. Changes.-AB*
- HB 278, *Bd. Of Chiropractic Examiners/Examination.*
- HB 825, *Meningitis & Hepatitis B Immunization Info.*
- HB 1063, *Summary Requirements/Child Care Facilities.*

III. Other Business

IV. Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 21, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, May 21, 2003 in Room 544 of the Legislative Office Building. Ten members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Purcell introduced Representative Setzer to explain H.B. 253, *Continuing Care Ret./Tech. Changes.* He told the committee that this bill was requested by the Department of Insurance and that there is an amendment. Senator Forrester offered the amendment and asked staff to explain it. He moved for adoption of the amendment and it passed. Representative Setzer asked Frank Folger of the Department of Insurance to speak on the bill. In response to a question from Senator Dannelly, Mr. Folger said that a provider with more than one facility must submit a statement for each facility owned. Senator Bingham suggested that the title be shortened. Senator Lucas moved to amend the bill title by shortening it. The amendment was read by staff and approved. Senator Forrester moved for a favorable report as amended, with the amendment rolled into a committee substitute. The motion passed.

Representative Bowie presented H.B. 825, *Meningitis and Hepatitis B Immunization Info* to the committee. Senator Lucas moved to approve the committee substitute for discussion. Representative Bowie explained that the "Hepatitis B" portion of the bill has been removed. Senator Kinnaird asked why Hepatitis B had been removed. Senator Purcell responded that the bill sponsors felt that it was no longer needed. Senator Dannelly moved for a favorable report for the committee substitute. The motion carried.

Representative McLawhorn presented the committee substitute for H.B. 1063, *Summary Requirements/Child Care Facilities* to the committee. Senator Kinnaird moved to adopt the committee substitute. Representative McLawhorn gave the committee a pamphlet entitled "North Carolina Child Care and Rules" and referred the committee to the section on "Reviewing Files" and said that this is what the bill is about and to create a public awareness of these laws. Senator Bingham proposed two amendments, one to substitute a word in the title, and one substituting a word on line 2. Senator Lucas proposed an amendment to change the title. These amendments passed. Senator Dannelly moved for a favorable report for the committee substitute as amended, and the motion carried.

Senator Purcell brought H.B. 278, *Bd. of Chiropractic Examiners/Examination* before the committee. He said that Representative Culpepper was not able to attend the meeting, and asked Dianna Jessup of the Research staff to explain the bill. Mr. Vance Kinlaw of the Board of Chiropractic Examiners responded to a question by Senator Dannelly regarding the phrase "successor organization". He said that there is no successor organization at this time and is not in the foreseeable future. Senator Malone moved for a favorable report and the motion carried.

The meeting adjourned at 11:35 A.M.

William R. Purcell

Senator William R. Purcell, Co-Chair

Stan Bingham

Senator Stan Bingham, Co-Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

CORRECTED REPORT

Thursday, May 22, 2003

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

FAVORABLE

H.B.(CS #1) **278** Bd of Chiropractic Examiners/Examination.

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) **825** Meningitis and Hepatitis B Immunization Info.

Draft Number:	PCS70325
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Tuesday, May 27, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B. **253** Continuing Care Ret./Tech. Changes.-AB

Draft Number:	PCS30344
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1063** Summary Requirements/Child Care Facilities.

Draft Number:	PCS50288
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 253

Short Title:	Continuing Care Ret./Tech. Changes.-AB	(Public)
Sponsors:	Representative Setzer.	
Referred to:	Insurance.	

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL ~~AND RELATED SUBSTANTIVE~~ CHANGES TO THE CONTINUING CARE RETIREMENT (CCR) LAWS.TO ELIMINATE THE UNNECESSARY PROVISION ALLOWING FOR ACCREDITED BUT UNLICENSED PROVIDERS OF CCR SERVICES; CHANGE REFERENCES FROM "FACILITY" TO "PROVIDER" WHERE APPROPRIATE TO ACCOMMODATE THE SITUATION WHERE AN ENTITY OPERATES MORE THAN ONE FACILITY; CHANGE "FORECAST" TO "FORECASTED" WHERE FOUND; CHANGE THE OPERATING RESERVES STATUTE BY REWORDING SOME PROVISIONS TECHNICALLY; CHANGE REFERENCES TO "REGISTRATION" OF A FACILITY TO "LICENSURE"; MAKE GENDER NEUTRAL CHANGES TO THE CCR LAWS; CLARIFY THAT A PROVIDER MUST HOLD SEMI-ANNUAL MEETINGS WITH THE RESIDENTS OF EACH FACILITY OPERATED BY THE PROVIDER; AND MAKE OTHER TECHNICAL AND CONFORMING CHANGES TO ARTICLE 64.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-64-5(e) is repealed.

SECTION 2. G.S. 58-64-5(g) reads as rewritten:

"(g) The Commissioner may require a ~~facility~~ provider to: (i) provide the report of an actuary that estimates the capacity of the provider to meet its contractual obligation to the resident, or (ii) give consideration to expected rates of mortality and morbidity, expected refunds, and expected capital expenditures in accordance with standards promulgated by the American Academy of Actuaries, within the five-year forecast statements, as required by G.S. 58-64-20(a)(12)."

SECTION 3. G.S. 58-64-20(a)(7)d. reads as rewritten:

"d. The conditions under which a living unit occupied by a resident may be made available by the ~~facility~~ provider to a different or new resident other than on the death of the prior resident; and".

SECTION 4. G.S. 58-64-20(a)(11) reads as rewritten:

"(11) In the event the ~~facility~~ provider has had an actuarial report prepared within the prior two years, the summary of a report of an actuary that estimates the capacity of the provider to meet its contractual obligations to the residents."

SECTION 5. G.S. 58-64-20(a)(12) reads as rewritten:

"(12) ~~Forecast~~ Forecasted financial statements for the ~~facility~~ provider of the next five years, including a balance sheet, a statement of operations, a statement of cash flows, and a statement detailing all significant assumptions, compiled by an independent certified public accountant. Reporting routine, categories, and structure may be further defined by regulations or forms adopted by the Commissioner."

SECTION 6. G.S. 58-64-20(a)(14)b. reads as rewritten:

"b. Narrative disclosure detailing all significant assumptions used in the preparation of the ~~forecast~~ forecasted financial statements, including:

1. Details of any long-term financing for the purchase or construction of the facility including interest rate, repayment terms, loan covenants, and assets pledged;
2. Details of any other funding sources that the provider anticipates using to fund any start-up losses or to provide reserve funds to assure full performance of the obligations of the provider under contracts for the provision of continuing care;
3. The total life occupancy fees to be received from or on behalf of, residents at, or prior to, commencement of operations along with anticipated accounting methods used in the recognition of revenues from and expected refunds of life occupancy fees;
4. A description of any equity capital to be received by the facility;
5. The cost of the acquisition of the facility or, if the facility is to be constructed, the estimated cost of the acquisition of the land and construction cost of the facility;
6. Related costs, such as financing any development costs that the provider expects to incur or become obligated for prior to the commencement of operations;
7. The marketing and resident acquisition costs to be incurred prior to commencement of operations; and
8. A description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies for health care services."

SECTION 7. G.S. 58-64-30(a) reads as rewritten:

"(a) Within 150 days following the end of each fiscal year, the provider shall file with the Commissioner a revised disclosure statement setting forth current information required pursuant to G.S. 58-64-20. The provider shall also make this revised disclosure statement available to all the residents of the facility. This revised disclosure statement shall include a narrative describing any material differences between (i) the ~~forecast~~ forecasted statements of revenues and expenses and cash flows or other ~~forecast~~ forecasted financial data filed pursuant to G.S. 58-64-20 as a part of the disclosure statement recorded most immediately subsequent to the start of the provider's most recently completed fiscal year and (ii) the actual results of operations during that fiscal year, together with the revised ~~forecast~~ forecasted statements of revenues and expenses and cash flows or other ~~forecast~~ forecasted financial data being filed as a part of the revised disclosure statement. A provider may also revise its disclosure statement and have the revised disclosure statement recorded at any other time if, in the opinion of the provider, revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 150 days prior to the date of delivery, shall be considered current for purposes of this Article or delivered pursuant to G.S. 58-64-20."

SECTION 8. G.S. 58-64-33 reads as rewritten:

"**§ 58-64-33. Operating reserves.**

(a) ~~All continuing care facilities~~ A provider shall maintain after ~~opening: the~~ opening of a facility: an operating ~~reserves~~ reserve equal to fifty percent (50%) of the total operating costs of the facility ~~projected~~ forecasted for the 12-month period following the period covered by the most recent ~~annual~~ disclosure statement filed with the Department. The forecast statements as required by G.S. 58-64-20(a)(12) shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service, consisting of principal and interest payments along with taxes and insurance on any mortgage loan or other long-term financing, but will exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded. ~~Facilities that maintain~~ If a facility maintains an occupancy level in excess of ninety percent ~~(90%)~~ (90%), a provider shall only be required to maintain a twenty-five percent (25%) operating reserve upon approval of the Commissioner, unless otherwise instructed by the Commissioner. The operating ~~reserves may~~ reserve must be funded by cash, by ~~invested cash,~~ cash equivalents, or by investment grade securities, including bonds, stocks, U.S. Treasury obligations, or obligations of U.S. government agencies.

(b) A provider that has begun construction or has permanent financing in place or is in operation on the effective date of this section has up to five years to meet the operating reserve requirements.

(c) ~~Operating reserves~~ An operating reserve shall only be released upon the submittal of a detailed request from the provider or facility and must be approved by the

Commissioner. Such requests must be submitted in writing for the Commissioner to review at least 10 business days prior to the date of withdrawal."

SECTION 9. G.S. 58-64-40 reads as rewritten:

"**§ 58-64-40. Right to organization.**

(a) A resident living in a facility ~~registered under this Article~~ operated by a provider licensed under this Article has the right of self-organization, the right to be represented by an individual of ~~his~~ the resident's own choosing, and the right to engage in concerted activities to keep informed on the operation of the facility in which ~~he is a resident~~ the resident resides or for other mutual aid or protection.

(b) The board of directors or other governing body of a ~~facility~~ provider or its designated representative shall hold semiannual meetings with the residents of ~~the facility~~ each facility operated by the provider for free discussions of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Upon request of the most representative residents' organization, a member of the governing body of the provider, such as a board member, a general partner, or a principal owner shall attend such meetings. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

SECTION 10. G.S. 58-64-45 reads as rewritten:

"**§ 58-64-45. Supervision, rehabilitation, and liquidation.**

(a) If, at any time, the Commissioner determines, after notice and an opportunity for the provider to be heard, that:

(1) A portion of an entrance fee escrow account required to be maintained under this Article has been or is proposed to be released in violation of this Article;

(2) A provider has been or will be unable, in such a manner as may endanger the ability of the provider, to fully perform its obligations pursuant to contracts for continuing care, to meet the ~~projected~~ forecasted financial data previously filed by the provider;

(3) A provider has failed to maintain the escrow account required under this Article; or

(4) A ~~facility~~ provider is bankrupt or insolvent, or in imminent danger of becoming bankrupt or insolvent;

the Commissioner may commence a supervision proceeding pursuant to Article 30 of this Chapter or may apply to the Superior Court of Wake County or to the federal bankruptcy court that may have previously taken jurisdiction over the provider or facility for an order directing the Commissioner or authorizing the Commissioner to rehabilitate or to liquidate a facility in accordance with Article 30 of this Chapter.

(b) The definition of "insolvency" or "insolvent" in G.S. 58-30-10(13) shall not apply to ~~facilities~~ providers under this Article. Rules adopted by the Commissioner shall define and describe "insolvency" or "hazardous financial condition" for ~~facilities~~

providers under this Article. G.S. 58-30-12 shall not apply to facilities under this Article.

(c) If, at any time, the Court finds, upon petition of the Commissioner or provider, or on its own motion, that the objectives of an order to rehabilitate a ~~facility~~ provider have been accomplished and that the facility or facilities owned by, or operated by, the provider can be returned to the provider's management without further jeopardy to the residents of the ~~facility,~~ facility or facilities, the Court may, upon a full report and accounting of the conduct of the ~~facility's~~ provider's affairs during the rehabilitation and of the ~~facility's~~ provider's current financial condition, terminate the rehabilitation and, by order, return the facility or facilities owned by, or operated by, the provider, along with the ~~and its~~ assets and affairs of the provider, to the provider's management.

(d), (e) Repealed by Session Laws 1995 (Regular Session, 1996), c. 582, s. 3.

(f) In applying for an order to rehabilitate or liquidate a ~~facility,~~ provider, the Commissioner shall give due consideration in the application to the manner in which the welfare of persons who have previously contracted with the provider for continuing care may be best served.

(g) An order for rehabilitation shall be refused or vacated if the provider posts a bond, by a recognized surety authorized to do business in this State and executed in favor of the Commissioner on behalf of persons who may be found entitled to a refund of entrance fees from the provider or other damages in the event the provider is unable to fulfill its contracts to provide continuing care at the ~~facility,~~ facility or facilities, in an amount determined by the Court to be equal to the reserve funding that would otherwise need to be available to fulfill such obligations."

SECTION 11. G.S. 58-64-46 reads as rewritten:

"**§ 58-64-46. Receiverships; exception for facility beds.**

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of adult care home beds ~~for that facility~~ for a facility owned by, or operated by, the provider, if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the ~~facility~~ provider or (ii) the welfare of persons who have previously contracted with the provider or may contract with the ~~facility,~~ provider, may be best served by the addition of adult care home beds."

SECTION 12. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a ~~facility~~ provider offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the ~~facility~~ provider examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

SECTION 13. G.S. 58-64-60 reads as rewritten:

"**§ 58-64-60. ~~Agreements~~Contracts as preferred claims on liquidation.**

In the event of liquidation of a provider, all contracts for continuing care ~~agreements~~ executed by the provider shall be deemed preferred claims against all assets owned by the provider; provided, however, such claims shall be subordinate to the liquidator's cost of administration or any secured claim."

SECTION 14. G.S. 58-64-65 reads as rewritten:

"**§ 58-64-65. Rule-making authority; reasonable time to comply with rules.**

(a) The Commissioner is authorized to promulgate rules to carry out and enforce the provisions of this Article.

(b) Any provider who is offering continuing care may be given a reasonable time, not to exceed one year from the date of publication of any applicable rules promulgated pursuant to this Article, within which to comply with the ~~rules and to obtain a license.~~rules."

SECTION 15. G.S. 58-64-70 reads as rewritten:

"**§ 58-64-70. Civil liability.**

(a) A provider who enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of G.S. 58-64-20 to the person contracting for this continuing care, or enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement that omits to state a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading, shall be liable to the person contracting for this continuing care for actual damages and repayment of all fees paid to the ~~provider, facility, or person~~ provider violating this Article, less the reasonable value of care and lodging provided to the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement, or omission or the time the violation, misstatement, or omission should reasonably have been discovered, together with interest thereon at the legal rate for judgments, and court costs and reasonable attorney fees.

(b) Liability under this section exists regardless of whether the provider ~~or person liable~~ had actual knowledge of the misstatement or omission.

(c) A person may not file or maintain an action under this section if the person, before filing the action, received a written offer of a refund of all amounts paid the provider, ~~facility, or person violating this Article~~ together with interest at the rate established monthly by the Commissioner of Banks pursuant to G.S. 24-1.1(c), less the current contractual value of care and lodging provided prior to receipt of the offer, and if the offer recited the provisions of this section and the recipient of the offer failed to accept it within 30 days of actual receipt.

(d) An action may not be maintained to enforce a liability created under this Article unless brought before the expiration of three years after the execution of the contract for continuing care that gave rise to the violation."

SECTION 16. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional, preempted, or otherwise invalid.

SECTION 17. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 253

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

H253-ASW-24 [v.1]

Date _____,2003

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Senator _____

moves to amend the bill on page 3, line 36, by deleting "~~reserves may~~ reserve must" and substituting "~~reserves may~~ reserve shall".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 253 DATE May 21, 2003

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Lucas
Sen.)

moves to amend the bill on page 1, lines 2-15

(✓) WHICH CHANGES THE TITLE

by rewriting the lines to read:

"AN ACT TO MAKE TECHNICAL CHANGES TO THE CONTINUING CARE RETIREMENT (CCR) LAWS." .

SIGNED Jeanne Lucas

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 253
PROPOSED SENATE COMMITTEE SUBSTITUTE H253-PCS30344-SP-10

Short Title: Continuing Care Ret./Tech. Changes.-AB (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES TO THE CONTINUING CARE RETIREMENT (CCR) LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-64-5(e) is repealed.

SECTION 2. G.S. 58-64-5(g) reads as rewritten:

"(g) The Commissioner may require a ~~facility~~ provider to: (i) provide the report of an actuary that estimates the capacity of the provider to meet its contractual obligation to the resident, or (ii) give consideration to expected rates of mortality and morbidity, expected refunds, and expected capital expenditures in accordance with standards promulgated by the American Academy of Actuaries, within the five-year forecast statements, as required by G.S. 58-64-20(a)(12)."

SECTION 3. G.S. 58-64-20(a)(7)d. reads as rewritten:

"d. The conditions under which a living unit occupied by a resident may be made available by the ~~facility~~ provider to a different or new resident other than on the death of the prior resident; and".

SECTION 4. G.S. 58-64-20(a)(11) reads as rewritten:

"(11) In the event the ~~facility~~ provider has had an actuarial report prepared within the prior two years, the summary of a report of an actuary that estimates the capacity of the provider to meet its contractual obligations to the residents."

SECTION 5. G.S. 58-64-20(a)(12) reads as rewritten:

"(12) ~~Forecast~~ Forecasted financial statements for the ~~facility~~ provider of the next five years, including a balance sheet, a statement of operations, a statement of cash flows, and a statement detailing all significant assumptions, compiled by an independent certified public accountant. Reporting routine, categories, and structure may be further defined by regulations or forms adopted by the Commissioner."

SECTION 6. G.S. 58-64-20(a)(14)b. reads as rewritten:

"b. Narrative disclosure detailing all significant assumptions used in the preparation of the ~~forecast~~ forecasted financial statements, including:

1. Details of any long-term financing for the purchase or construction of the facility including interest rate, repayment terms, loan covenants, and assets pledged;
2. Details of any other funding sources that the provider anticipates using to fund any start-up losses or to provide reserve funds to assure full performance of the obligations of the provider under contracts for the provision of continuing care;
3. The total life occupancy fees to be received from or on behalf of, residents at, or prior to, commencement of operations along with anticipated accounting methods used in the recognition of revenues from and expected refunds of life occupancy fees;
4. A description of any equity capital to be received by the facility;
5. The cost of the acquisition of the facility or, if the facility is to be constructed, the estimated cost of the acquisition of the land and construction cost of the facility;
6. Related costs, such as financing any development costs that the provider expects to incur or become obligated for prior to the commencement of operations;
7. The marketing and resident acquisition costs to be incurred prior to commencement of operations; and
8. A description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies for health care services."

SECTION 7. G.S. 58-64-30(a) reads as rewritten:

"(a) Within 150 days following the end of each fiscal year, the provider shall file with the Commissioner a revised disclosure statement setting forth current information required pursuant to G.S. 58-64-20. The provider shall also make this revised disclosure statement available to all the residents of the facility. This revised disclosure statement shall include a narrative describing any material differences between (i) the ~~forecast~~ forecasted statements of revenues and expenses and cash flows or other ~~forecast~~ forecasted financial data filed pursuant to G.S. 58-64-20 as a part of the disclosure statement recorded most immediately subsequent to the start of the provider's most recently completed fiscal year and (ii) the actual results of operations during that fiscal year, together with the revised ~~forecast~~ forecasted statements of revenues and expenses and cash flows or other ~~forecast~~ forecasted financial data being filed as a part of the

revised disclosure statement. A provider may also revise its disclosure statement and have the revised disclosure statement recorded at any other time if, in the opinion of the provider, revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 150 days prior to the date of delivery, shall be considered current for purposes of this Article or delivered pursuant to G.S. 58-64-20."

SECTION 8. G.S. 58-64-33 reads as rewritten:

"**§ 58-64-33. Operating reserves.**

(a) ~~All continuing care facilities~~ A provider shall maintain after ~~opening: the~~ opening of a facility: an operating ~~reserves~~ reserve equal to fifty percent (50%) of the total operating costs of the facility ~~projected~~ forecasted for the 12-month period following the period covered by the most recent ~~annual~~ disclosure statement filed with the Department. The forecast statements as required by G.S. 58-64-20(a)(12) shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service, consisting of principal and interest payments along with taxes and insurance on any mortgage loan or other long-term financing, but will exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded. ~~Facilities that maintain~~ If a facility maintains an occupancy level in excess of ninety percent ~~(90%)~~ (90%), a provider shall only be required to maintain a twenty-five percent (25%) operating reserve upon approval of the Commissioner, unless otherwise instructed by the Commissioner. The operating ~~reserves may~~ reserve must be funded by cash, by ~~invested cash,~~ cash equivalents, or by investment grade securities, including bonds, stocks, U.S. Treasury obligations, or obligations of U.S. government agencies.

(b) A provider that has begun construction or has permanent financing in place or is in operation on the effective date of this section has up to five years to meet the operating reserve requirements.

(c) ~~Operating reserves~~ An operating reserve shall only be released upon the submittal of a detailed request from the provider or facility and must be approved by the Commissioner. Such requests must be submitted in writing for the Commissioner to review at least 10 business days prior to the date of withdrawal."

SECTION 9. G.S. 58-64-40 reads as rewritten:

"**§ 58-64-40. Right to organization.**

(a) A resident living in a facility ~~registered under this Article~~ operated by a provider licensed under this Article has the right of self-organization, the right to be represented by an individual of ~~his~~ the resident's own choosing, and the right to engage in concerted activities to keep informed on the operation of the facility in which ~~he is a resident~~ the resident resides or for other mutual aid or protection.

(b) The board of directors or other governing body of a ~~facility~~ provider or its designated representative shall hold semiannual meetings with the residents of ~~the facility~~ each facility operated by the provider for free discussions of subjects including,

but not limited to, income, expenditures, and financial trends and problems as they apply to the facility and discussions of proposed changes in policies, programs, and services. Upon request of the most representative residents' organization, a member of the governing body of the provider, such as a board member, a general partner, or a principal owner shall attend such meetings. Residents shall be entitled to at least seven days advance notice of each meeting. An agenda and any materials that will be distributed by the governing body at the meetings shall remain available upon request to residents."

SECTION 10. G.S. 58-64-45 reads as rewritten:

"**§ 58-64-45. Supervision, rehabilitation, and liquidation.**

(a) If, at any time, the Commissioner determines, after notice and an opportunity for the provider to be heard, that:

(1) A portion of an entrance fee escrow account required to be maintained under this Article has been or is proposed to be released in violation of this Article;

(2) A provider has been or will be unable, in such a manner as may endanger the ability of the provider, to fully perform its obligations pursuant to contracts for continuing care, to meet the ~~projected~~ forecasted financial data previously filed by the provider;

(3) A provider has failed to maintain the escrow account required under this Article; or

(4) A ~~facility~~ provider is bankrupt or insolvent, or in imminent danger of becoming bankrupt or insolvent;

the Commissioner may commence a supervision proceeding pursuant to Article 30 of this Chapter or may apply to the Superior Court of Wake County or to the federal bankruptcy court that may have previously taken jurisdiction over the provider or facility for an order directing the Commissioner or authorizing the Commissioner to rehabilitate or to liquidate a facility in accordance with Article 30 of this Chapter.

(b) The definition of "insolvency" or "insolvent" in G.S. 58-30-10(13) shall not apply to ~~facilities~~ providers under this Article. Rules adopted by the Commissioner shall define and describe "insolvency" or "hazardous financial condition" for ~~facilities~~ providers under this Article. G.S. 58-30-12 shall not apply to facilities under this Article.

(c) If, at any time, the Court finds, upon petition of the Commissioner or provider, or on its own motion, that the objectives of an order to rehabilitate a ~~facility~~ provider have been accomplished and that the facility or facilities owned by, or operated by, the provider can be returned to the provider's management without further jeopardy to the residents of the ~~facility,~~ facility or facilities, the Court may, upon a full report and accounting of the conduct of the ~~facility's~~ provider's affairs during the rehabilitation and of the ~~facility's~~ provider's current financial condition, terminate the rehabilitation and, by order, return the facility or facilities owned by, or operated by, the provider, along with the ~~and its~~ assets and affairs of the provider, to the provider's management.

(d), (e) Repealed by Session Laws 1995 (Regular Session, 1996), c. 582, s. 3.

(f) In applying for an order to rehabilitate or liquidate a ~~facility,~~ provider, the Commissioner shall give due consideration in the application to the manner in which the welfare of persons who have previously contracted with the provider for continuing care may be best served.

(g) An order for rehabilitation shall be refused or vacated if the provider posts a bond, by a recognized surety authorized to do business in this State and executed in favor of the Commissioner on behalf of persons who may be found entitled to a refund of entrance fees from the provider or other damages in the event the provider is unable to fulfill its contracts to provide continuing care at the ~~facility,~~ facility or facilities, in an amount determined by the Court to be equal to the reserve funding that would otherwise need to be available to fulfill such obligations."

SECTION 11. G.S. 58-64-46 reads as rewritten:

"**§ 58-64-46. Receiverships; exception for facility beds.**

When the Commissioner has been appointed as a receiver under Article 30 of this Chapter for a provider or facility subject to this Article, the Department of Health and Human Services may, notwithstanding any other provision of law, accept and approve the addition of adult care home beds ~~for that facility~~ for a facility owned by, or operated by, the provider, if it appears to the court, upon petition of the Commissioner or the provider, or on the court's own motion, that (i) the best interests of the ~~facility~~ provider or (ii) the welfare of persons who have previously contracted with the provider or may contract with the ~~facility,~~ provider, may be best served by the addition of adult care home beds."

SECTION 12. G.S. 58-64-55 reads as rewritten:

"**§ 58-64-55. Examinations; financial statements.**

The Commissioner or the Commissioner's designee may, in the Commissioner's discretion, visit a ~~facility~~ provider offering continuing care in this State to examine its books and records. Expenses incurred by the Commissioner in conducting examinations under this section shall be paid by the ~~facility~~ provider examined. The provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, and 58-6-5 apply to this Article and are hereby incorporated by reference."

SECTION 13. G.S. 58-64-60 reads as rewritten:

"**§ 58-64-60. ~~Agreements~~Contracts as preferred claims on liquidation.**

In the event of liquidation of a provider, all contracts for continuing care ~~agreements~~ executed by the provider shall be deemed preferred claims against all assets owned by the provider; provided, however, such claims shall be subordinate to the liquidator's cost of administration or any secured claim."

SECTION 14. G.S. 58-64-65 reads as rewritten:

"**§ 58-64-65. Rule-making authority; reasonable time to comply with rules.**

(a) The Commissioner is authorized to promulgate rules to carry out and enforce the provisions of this Article.

(b) Any provider who is offering continuing care may be given a reasonable time, not to exceed one year from the date of publication of any applicable rules promulgated pursuant to this Article, within which to comply with the ~~rules and to obtain a license.~~rules."

SECTION 15. G.S. 58-64-70 reads as rewritten:

"**§ 58-64-70. Civil liability.**

(a) A provider who enters into a contract for continuing care at a facility without having first delivered a disclosure statement meeting the requirements of G.S. 58-64-20 to the person contracting for this continuing care, or enters into a contract for continuing care at a facility with a person who has relied on a disclosure statement that omits to state a material fact required to be stated therein or necessary in order to make the statements made therein, in light of the circumstances under which they are made, not misleading, shall be liable to the person contracting for this continuing care for actual damages and repayment of all fees paid to the ~~provider, facility, or person~~ provider violating this Article, less the reasonable value of care and lodging provided to the resident by or on whose behalf the contract for continuing care was entered into prior to discovery of the violation, misstatement, or omission or the time the violation, misstatement, or omission should reasonably have been discovered, together with interest thereon at the legal rate for judgments, and court costs and reasonable attorney fees.

(b) Liability under this section exists regardless of whether the provider ~~or person liable~~ had actual knowledge of the misstatement or omission.

(c) A person may not file or maintain an action under this section if the person, before filing the action, received a written offer of a refund of all amounts paid the provider, ~~facility, or person violating this Article~~ together with interest at the rate established monthly by the Commissioner of Banks pursuant to G.S. 24-1.1(c), less the current contractual value of care and lodging provided prior to receipt of the offer, and if the offer recited the provisions of this section and the recipient of the offer failed to accept it within 30 days of actual receipt.

(d) An action may not be maintained to enforce a liability created under this Article unless brought before the expiration of three years after the execution of the contract for continuing care that gave rise to the violation."

SECTION 16. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional, preempted, or otherwise invalid.

SECTION 17. This act is effective when it becomes law.

HOUSE BILL 253:
Continuing Care Ret./Tech. Changes

BILL ANALYSIS

Committee:	Senate Health and Human Services	**Introduced by:**	Rep. Setzer
		Summary by:	Sandra Alley Committee Counsel
Date:	May 7, 2003		
Version:	First Edition		

SUMMARY: H253 makes numerous technical changes to law governing the licensing and operation of continuing care retirement communities. The bill is effective when it becomes law.

CURRENT LAW: Continuing care retirement communities (CCRCs) are also known as continuing care facilities and life-care communities. These facilities provide housing and health-related services either for life or for a period in excess of one year. CCRCs provide independent living and also offer nursing home or adult care home level of care. Because CCRCs include contractual requirements where, for certain fees, the facility agrees to provide health care coverage over a given period of time, they are considered an insurance product and are regulated by the Department of Insurance under Article 64 of Chapter 58. They are also licensed by the State Division of Facility Services for the adult care home or nursing home level of care they provide.

The following terms are defined by G.S. 58-64-1:

"Continuing Care" means the furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under an agreement effective for the life of the individual or for a period longer than one year.

"Facility" means the retirement community or communities in which a provider undertakes to provide continuing care to an individual.

"Provider" means the promoter, developer, or owner of a facility, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents himself, herself, or itself as providing continuing care or "life care".

BILL ANALYSIS: See attached DOI's summary for section-by-section explanation.

BACKGROUND:

The typical CCRC provides independent accommodations that may include full or efficiency apartments, villas, or cluster homes as well as community dining, social and recreational areas, and a wide range of services including meals, housekeeping, transportation, and health-related services. Depending on the individual community, these accommodations, activities, and services may be paid for in a monthly fee or purchased as needed. Usually a substantial entrance fee is charged in addition to monthly fees. Entrance fees can be non-refundable, partially refundable, or fully refundable. The majority of CCRCs are private pay, although a few have some subsidized units. (Source: North Carolina Division of Aging, DHHS).

DEPARTMENT OF INSURANCE

State of North Carolina

P. O. Box 26387
RALEIGH, N. C. 27611

JIM LONG
COMMISSIONER OF INSURANCE

LEGISLATIVE COUNSEL
(919) 733-4529

MEMORANDUM

TO: Senate Committee on Health & Human Resources

FROM: Frank W. Folger, Legislative Counsel

DATE: May 21, 2003

HOUSE BILL 253 – CONTINUING CARE RETIREMENT/TECHINICAL CHANGES/AB
Section-by-Section Bill Summary

Section 1. Repeals an unused, and likely unusable, provision (G.S. 58-64-5(e)) allowing for a continuing care retirement facility that is accredited under a process approved by the Commissioner to be issued a license based on that accreditation.

Sections 2. through 4. Replaces the word "facility" with "provider" to clarify that it is the provider that operates the facility that is responsible for meeting these various statutory requirements.

Section 5. Changes the word "forecast" to "forecasted" when it appears and replaces the word "facility" with "provider" consistent with the changes and rationale for Sections 2. through 4.

Sections 6 and 7. Changes the word "forecast" to "forecasted" in G.S. 58-64-20(a)(14) b. and 58-64-30(a) whenever it appears.

Section 8. Rewords for clarity language in G.S. 58-64-33, governing operating reserves for continuing care retirement facilities and providers, including:

- Changing the wording in subsection(a) to reflect the fact that a provider is to calculate and maintain a separate operating reserve for each continuing care facility operated by the provider.
- Changing the words "annual statement" to "disclosure statement" subsection (a).
- Changing the words "invested cash" to "cash equivalents" in subsection (a).

Section 9. Makes the following changes to G.S. 58-64-40 governing the rights of residents of continuing care retirement facilities to organize:

- Changed "registered under this Article" to "operated by a provider licensed under this Article" in G.S. 58-64-40(a). No entity is "registered" under G.S. 58-64.
- Made gender neutral corrections.
- Changed the word "facility" to "provider" where appropriate.
- Clarified that the governing body of a provider must hold semi-annual meetings with the residents of each facility operated by the provider.

Section 10. Makes various changes to G.S. 58-64-45, governing supervision, rehabilitation and liquidation of continuing care retirement providers including:

- Replacing the word "projected" with "forecasted" in subsection (a).
- Changing the words "facility" and "facilities" to "provider" and "providers", respectively, throughout the statute, where appropriate.
- Adding the words "or facilities owned by, or operated by, the provider" or otherwise amending the statute as necessary to accommodate the fact that a provider can own or operate more than one facility.

Section 11. Amends G.S. 58-64-46, on receiverships, to reflect the fact that the Commissioner would be appointed as receiver for a provider not a facility.

Section 12. Replaces twice the word "facility" with "provider" in G.S. 58-64-55, governing examinations and financial statements.

Section 13. Replaces the word "agreements" with "contracts" for consistency of wording within Article 64.

Section 14. Removes unnecessary language from G.S. 58-64-65 to conform with the removal of the "accredited facility" provision in Section 1. of the bill.

Section 15. Amends G.S. 58-64-70, governing civil liability, to:

- Remove the misleading words "facility, or person violating this Article" in subsection (a) because the provider is the entity entering into a contract for continuing care, not the facility or other person.

- Remove the words "or person liable" because the provider is the only entity that is required to deliver a disclosure statement to the contracting party.

- Remove the words "facility, or person" since payment is made to the provider, and the provider is the entity responsible for the dissemination of the disclosure statement.

Section 16. Is a severability clause to protect the remaining provisions of the bill if a portion is declared unconstitutional, unenforceable, or otherwise invalid.

Section 17. Makes the act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 3

HOUSE BILL 278

Committee Substitute Favorable 4/29/03
Corrected Copy 4/30/03

Short Title: Bd. of Chiropractic Examiners/Examination. (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING EXAMINATIONS FOR LICENSURE TO PRACTICE CHIROPRACTIC.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-143 reads as rewritten:

"**§ 90-143. Definitions of chiropractic; examinations; educational requirements.**

(a) "Chiropractic" is herein defined to be the science of adjusting the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry their full quota of health current (nerve energy) from the brain to all parts of the body.

(b) It shall be the duty of the North Carolina State Board of Chiropractic Examiners (hereinafter referred to as "Board") to examine for licensure to practice chiropractic in this State any applicant who is or will become, within 60 days of examination, a graduate of a four-year chiropractic college that is either accredited by the Council on Chiropractic Education or deemed by the Board to be the equivalent of such a college and who furnishes to the Board, in the manner prescribed by the Board, all of the following:

(1) Satisfactory evidence of good moral character.

(2) Proof that the applicant has received a baccalaureate degree from a college or university accredited by a regional accreditation body recognized by the United States Department of Education.

(3) A transcript confirming that the applicant has received at least 4,200 hours of accredited chiropractic education. The Board shall not count any hours earned at an institution that was not accredited by the Council on Chiropractic Education or was not, as determined by the Board, the equivalent of such an institution at the time the hours were earned.

The examination shall ~~include, but not be limited to,~~ include the following studies: neurology, chemistry, pathology, anatomy, histology, physiology, embryology, dermatology, diagnosis, microscopy, gynecology, hygiene, eye, ear, nose and throat, orthopody, diagnostic radiology, North Carolina jurisprudence, palpation, nerve tracing, chiropractic philosophy, theory, teaching and practice of ~~chiropractic.~~chiropractic, and any other related studies as the Board may consider necessary to determine an applicant's fitness to practice. The Board may include as part of the examination any examination developed and administered by the National Board of Chiropractic Examiners or its successor organization that the Board considers appropriate, and the examination may be administered by a national testing service. The Board shall set the passing scores for all parts of the examination.

(c) The Board shall not issue a license to any applicant until the applicant exhibits a diploma or other proof that the Doctor of Chiropractic degree has been conferred.

(d) The Board may grant a license to an applicant if the applicant's scores on all parts of the examination ~~given by the National Board of Chiropractic Examiners~~ required by the Board equal or exceed passing scores ~~on the Board's examination,~~ set by the Board and the applicant satisfies all other requirements for licensure as provided in this Article."

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

HOUSE BILL 278:
Board of Chiropractic Examiner/Examination

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Rep. Culpepper
		Summary by:	Dianna Jessup Committee Counsel
Date:	May 21, 2003		
Version:	Third Edition		

SUMMARY: ***House Bill 278 would amend the chiropractic licensure to permit the Board of Chiropractic Examiners to use examinations developed and administered by the National Board of Chiropractic Examiners as part of the examination required for licensure in this State. The act would become effective when it becomes law.***

CURRENT LAW: The North Carolina State Board of Chiropractic Examiners (Board) examines applicants for licensure to practice chiropractic in this State. The examination must include, but not be limited to, certain studies specified under G.S. 90-143 (b).

BILL ANALYSIS: House Bill 278 would clarify that the examination may include any other related studies the Board considers necessary to determine an applicant's fitness to practice. In addition, the bill would give the Board the authority to use examinations developed and administered by the National Board of Chiropractic Examiners as part of the required examination and would permit the examination to be administered by a national testing service. The Board would set the passing scores for all parts of the examination. Finally, the bill would specify that the Board may grant a license to an applicant if the applicant's scores on all parts of the examination required by the Board equal or exceed the passing scores set by the Board.

BACKGROUND: There are other Boards that have the authority to use, in some form, national examinations:

NORTH CAROLINA MEDICAL BOARD: *G.S. 90-10. Provision in lieu of examination in Article 1 Practice of Medicine of Chapter 90:* In lieu of the above examination, the Board may grant a license to an applicant who is found to have passed the examination given by the National Board of Medical Examiners, or who has passed such other examination which the Board deems to be equivalent to the examination given by the Board, provided the applicant meets the other qualifications set forth in this Article.

NORTH CAROLINA PSYCHOLOGY BOARD: *G.S. 90-270.2 under Article 18A, Psychology Practice Act of Chapter 90* defines "Examination" to mean: Any and all examinations that are adopted by the Board and administered to applicants and licensees, including, but not limited to, the national examination, Board-developed examinations, and other examinations that assess the competency and ethics of psychologists and applicants.

NORTH CAROLINA BOARD OF DIETETICS/NUTRITION: *G.S. 90-359 Examinations under Article 25, Dietetics/Nutrition of Chapter 90*: Competency examinations shall be administered at least twice each year to qualified applicants for licensing. The examinations may be administered by a national testing service. The Board shall prescribe or develop the examinations which may include an examination

given by the Commission on Dietetic Registration of the American Dietetic Association or any other examination approved by two-thirds vote of the entire Board.

NORTH CAROLINA RESPIRATORY CARE BOARD: *G.S. 90-653(5) Licensure requirements; examination under Article 38, Respiratory Care Practice Act, of Chapter 90* requires the applicant to pass the entry-level examination given by the National Board for Respiratory Care, Inc.

BOARD OF PODIATRY EXAMINERS: *G.S. 90-202.6 (b) Examinations; subjects; certificates in Article 12A Podiatrists of Chapter 90:* The Board may waive the administration of a written examination prepared by it for all initial applicants who have successfully completed the National Board of Podiatry Examination. The Board may administer to such applicants and require them to complete successfully an examination to test clinical competency in the practice of podiatry.

NORTH CAROLINA STATE BOARD OF OPTICIANS: *G.S. 90-240 (e) Examination under Article 17, Dispensing Opticians, of Chapter 90*: The Board may include as part or all of the examination, any nationally prepared and recognized examination, and will periodically review and validate any exam in use by the Board. The Board will credit an applicant with the score on any national test taken in the last three years to the extent such test may be included in the North Carolina exam.

H278-SMSW-001

Amy Compeau, Research Assistant, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 825

Committee Substitute Favorable 4/24/03

Short Title: Meningitis & Hepatitis B Immunization Info. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL AND HEPATITIS B IMMUNIZATION INFORMATION TO NEWLY ENROLLED STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new Article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningococcal and hepatitis B immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide vaccination information on meningococcal and hepatitis B diseases to each student. The vaccination information shall be contained on student health forms provided to each student by the educational institution and shall include space for the student to indicate whether or not the student has received the vaccination against the diseases. The vaccination information about meningococcal and hepatitis B diseases shall include any recommendations issued by the national Centers for Disease Control and Prevention regarding the diseases.

(b) The vaccination information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningococcal and hepatitis B vaccinations to students.

(d) This section shall not apply if the national Centers for Disease Control and Prevention no longer recommends the vaccinations in this section for the general population.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 825

Committee Substitute Favorable 4/24/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H825-CSRJ-22 [v.1]

5/15/2003 3:56:10 PM

Short Title: Meningitis Immunization Info. (Public)

Sponsors:

Referred to:

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANY PRIVATE OR PUBLIC INSTITUTION THAT OFFERS A POSTSECONDARY DEGREE TO PROVIDE MENINGOCOCCAL DISEASE IMMUNIZATION INFORMATION TO STUDENTS IF THE INSTITUTION HAS A RESIDENTIAL CAMPUS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new Article to read:

"Article 32.

"Health Information.

"**§ 116-260. Information on meningococcal disease immunization.**

(a) Each public or private educational institution that offers a postsecondary degree as defined in G.S. 116-15 and that has a residential campus shall provide vaccination information on meningococcal disease to each student. The vaccination information shall be contained on student health forms provided to each student by the educational institution and shall include space for the student to indicate whether or not the student has received the vaccination against meningococcal disease. The vaccination information about meningococcal disease shall include any recommendations issued by the national Centers for Disease Control and Prevention regarding the disease.

(b) The vaccination information obtained under this section that is in the possession of the educational institution is confidential and shall not be a public record under G.S. 132-1.

(c) This section shall not be construed to require the educational institution to provide the meningococcal vaccination to students.

(d) This section shall not apply if the national Centers for Disease Control and Prevention no longer recommends the meningococcal vaccine.

(e) This section does not create a private right of action."

SECTION 2. This act is effective when it becomes law and applies to the 2003-2004 academic year and each subsequent year.

HOUSE BILL 825:
Meningitis Immunization Info.

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Reps. Grady, Bowie and Glazier
Date:	May 21, 2003		
Version:	PCS for Second Edition H825-CSRJ-22[v.1]	**Summary by:**	Sara Kamprath Committee Analyst

BILL ANALYSIS: The proposed committee substitute for House Bill 825 creates a new section in Chapter 116 of the General Statutes relating to certain public and private educational institutions with a residential campus providing vaccination information on meningococcal disease to each student. The vaccination information shall be included on the student health form provided to each student and shall include any recommendations from the Centers for Disease Control and Prevention regarding the disease. The health form shall provide space for the student to indicate whether he has received the vaccination. The vaccination information obtained under this section is confidential and shall not be a public record under G.S. 132-1.

The educational institution is not required to provide the meningococcal vaccination to students. If the national Centers for Disease Control and Prevention no longer recommends the meningococcal vaccination then the section does not apply. The section does not create a private right of action.

The bill is effective when it becomes law and applies beginning with the 2003-04 academic year.

BACKGROUND: G.S. 130A-155.1 provides that no person can attend a public, private or religious college or university without presenting a certificate of immunization or a record of immunization from a NC high school. The document must indicate that the person has received the immunizations required by G.S. 130A-152. If the information is not available when the person first registers then the person shall have a certain amount of time to get the required immunization. If the person has not received the immunization within that time period then the student will have to withdraw. Currently, the meningococcal vaccination is not required.

Meningitis is an infection of the fluid of the spinal cord and the fluid that surrounds the brain. The disease is usually caused by a viral or bacterial infection. Bacterial meningitis may result in brain damage, hearing loss, learning disability and sometimes death. The Journal of the American Medical Association recently reported that freshmen living in dormitories have a higher risk of getting meningococcal disease than college students overall. The Centers for Disease Control and Prevention recommends that colleges and universities provide information about meningococcal disease and the vaccine to freshmen, especially those planning to live in dorms or residence halls.

H825-SMRJ-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **2**

HOUSE BILL 1063

Committee Substitute Favorable 4/24/03

Short Title: Summary Requirements/Child Care Facilities. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE OPERATORS OF CHILD CARE FACILITIES TO DISCUSS THE DIVISION OF CHILD DEVELOPMENT'S SUMMARY OF THE LAWS RELATING TO CHILD CARE FACILITIES WITH PARENTS, TO REQUIRE THE DIVISION OF CHILD DEVELOPMENT TO INCLUDE IN ITS SUMMARY A STATEMENT ON HOW PARENTS MAY OBTAIN INFORMATION ON INDIVIDUAL CHILD CARE FACILITIES, AND TO REQUIRE CHILD CARE FACILITIES TO POST THE SUMMARY IN A PROMINENT PLACE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-102 reads as rewritten:

"**§ 110-102. Information for parents.**

The Secretary shall provide to each operator of a child care facility a summary of this Article for the parents, guardian, or full-time custodian of each child receiving child care in the facility to be distributed by the operator. Operators of child care facilities shall provide a copy of the summary to each child's parent, guardian, or full-time custodian before the child is enrolled in the child care facility. The child's parent, guardian, or full-time custodian shall sign a statement attesting that he or she received a copy of the summary before the child's enrollment. The summary shall include the name and address of the Secretary and the address of the Commission. The summary shall explain how parents may obtain information on individual child care facilities maintained in public files by the Division of Child Development. The summary shall also include a statement regarding the mandatory duty prescribed in G.S. 7B-301 of any person suspecting child abuse or neglect has taken place in child care, or elsewhere, to report to the county Department of Social Services. The statement shall include the definitions of child abuse and neglect described in the Juvenile Code in G.S. 7B-101 and of child abuse described in the Criminal Code in G.S. 14-318.2 and G.S. 14-318.4. The statement shall stress that this reporting law does not require that the person reporting reveal the person's identity.

The summary of this Article shall be posted with the facility's license in accordance with G.S. 110-99. Religious-sponsored programs operating pursuant to G.S. 110-106 shall post the summary in a prominent place at all times so that it is easily reviewed by parents."

SECTION 2. This act becomes effective October 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1063

Committee Substitute Favorable 4/24/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H1063-PCS50288-SP-9

Short Title: Summary Requirements/Child Care Facilities. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE OPERATORS OF CHILD CARE FACILITIES TO PROVIDE TO PARENTS THE DIVISION OF CHILD DEVELOPMENT'S SUMMARY OF THE LAWS RELATING TO CHILD CARE FACILITIES, TO REQUIRE THE DIVISION OF CHILD DEVELOPMENT TO INCLUDE IN ITS SUMMARY A STATEMENT ON HOW PARENTS MAY OBTAIN INFORMATION ON INDIVIDUAL CHILD CARE FACILITIES, AND TO REQUIRE CHILD CARE FACILITIES TO POST THE SUMMARY IN A PROMINENT PLACE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-102 reads as rewritten:

"**§ 110-102. Information for parents.**

The Secretary shall provide to each operator of a child care facility a summary of this Article for the parents, guardian, or full-time custodian of each child receiving child care in the facility to be distributed by the operator. Operators of child care facilities shall provide a copy of the summary to each child's parent, guardian, or full-time custodian before the child is enrolled in the child care facility. The child's parent, guardian, or full-time custodian shall sign a statement attesting that he or she received a copy of the summary before the child's enrollment. The summary shall include the name and address of the Secretary and the address of the Commission. The summary shall explain how parents may obtain information on individual child care facilities maintained in public files by the Division of Child Development. The summary shall also include a statement regarding the mandatory duty prescribed in G.S. 7B-301 of any person suspecting child abuse or neglect has taken place in child care, or elsewhere, to report to the county Department of Social Services. The statement shall include the definitions of child abuse and neglect described in the Juvenile Code in G.S. 7B-101 and of child abuse described in the Criminal Code in G.S. 14-318.2 and G.S. 14-318.4.

The statement shall stress that this reporting law does not require that the person reporting reveal the person's identity.

The summary of this Article shall be posted with the facility's license in accordance with G.S. 110-99. Religious-sponsored programs operating pursuant to G.S. 110-106 shall post the summary in a prominent place at all times so that it is easily reviewed by parents."

SECTION 2. This act becomes effective October 1, 2003.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. H1063 DATE May 21, 2003

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page 1, lines 2-4
2 ( ) WHICH CHANGES THE TITLE
3 by rewriting lines 2-4 to read:
4
5 " AN ACT TO REQUIRE OPERATORS OF CHILD CARE FACILITIES
6 PROVIDE TO ← TO PARENTS THE DIVISION OF CHILD DEVELOPMENT'S
7 SUMMARY OF THE LAWS RELATING TO CHILD CARE
8 FACILITIES, TO REQUIRE ".
9
10
11
12
13
14
15
16
17
18
19

SIGNED Jeanne Lucas

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1063

Committee Substitute Favorable 4/24/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H1063-CSSP-7 [v.2]

5/20/2003 3:44:56 PM

Short Title: Summary Requirements/Child Care Facilities. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE OPERATORS OF CHILD CARE FACILITIES TO PROVIDE THE DIVISION OF CHILD DEVELOPMENT'S SUMMARY OF THE LAWS RELATING TO CHILD CARE FACILITIES TO PARENTS, TO REQUIRE THE DIVISION OF CHILD DEVELOPMENT TO INCLUDE IN ITS SUMMARY A STATEMENT ON HOW PARENTS MAY OBTAIN INFORMATION ON INDIVIDUAL CHILD CARE FACILITIES, AND TO REQUIRE CHILD CARE FACILITIES TO POST THE SUMMARY IN A PROMINENT PLACE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-102 reads as rewritten:

"**§ 110-102. Information for parents.**

The Secretary shall provide to each operator of a child care facility a summary of this Article for the parents, guardian, or full-time custodian of each child receiving child care in the facility to be distributed by the operator. Operators of child care facilities shall provide a copy of the summary to each child's parent, guardian, or full-time custodian before the child is enrolled in the child care facility. The child's parent, guardian, or full-time custodian shall sign a statement attesting that he or she received a copy of the summary before the child's enrollment. The summary shall include the name and address of the Secretary and the address of the Commission. The summary shall explain how parents may obtain information on individual child care facilities maintained in public files by the Division of Child Development. The summary shall also include a statement regarding the mandatory duty prescribed in G.S. 7B-301 of any person suspecting child abuse or neglect has taken place in child care, or elsewhere, to report to the county Department of Social Services. The statement shall include the definitions of child abuse and neglect described in the Juvenile Code in G.S. 7B-101 and of child abuse described in the Criminal Code in G.S. 14-318.2 and G.S. 14-318.4.

The statement shall stress that this reporting law does not require that the person reporting reveal the person's identity.

The summary of this Article shall be posted with the facility's license in accordance with G.S. 110-99. Religious-sponsored programs operating pursuant to G.S. 110-106 shall post the summary in a prominent place at all times so that it is easily reviewed by parents."

SECTION 2. This act becomes effective October 1, 2003.

HOUSE BILL 1063:
Summary Requirements/Child Care Facilities

BILL ANALYSIS

Committee:	Sen. Health & Human Services	**Introduced by:**	Representative McLawhorn
Date:	May 21, 2003	**Summary by:**	Sandra Alley
Version:	Second Edition		Committee Counsel

SUMMARY: ***House Bill 1063, Second Edition, would require operators of child care facilities to provide the Division of Child Development's summary of child care laws to parents and post the summary in a prominent place in the facility. The summary would include a statement on how parents may obtain information on specific child care facilities. The bill would become effective October 1, 2003.***

CURRENT LAW: Article 7 of Chapter 110 of the General Statutes sets out requirements for the provision of child care by child care facilities. Child care facilities must meet certain minimum requirements to be licensed to operate in North Carolina. G.S. 110-102 requires the Secretary of the Department of Health and Human Services to provide operators of child care facilities with a summary of the requirements for child care under Article 7. The summary is to be distributed to parents, guardians, and full-time custodians of children receiving child care in the facility. An operator who violates the provisions of G.S. 110-102 shall be guilty of a Class 1 misdemeanor, except that a family child care home operator shall be guilty of a Class 3 misdemeanor.

Religious sponsored child care facilities must meet applicable minimum standards for child care facilities. Religious sponsored child care facilities including summer day camps are exempt form licensure requirements, and the State may not regulate the religious training offered as a part of any religious sponsored child care program.

BILL ANALYSIS: House Bill 1063, Second Edition, would require operators of child care facilities to provide the summary of Article 7 to a child's parent before the child is enrolled in the facility, and the parent would be required to sign a statement attesting that he or she received a copy of the summary and that the summary was discussed with him or her. The summary would have to include a statement on how parents can obtain information on individual child care facilities from the North Carolina Division of Child Development.

In addition, the bill would require that the summary be posted in the same manner as the facility's license, as required by G.S. 110-99. Religious sponsored child care facilities would also be required to post the summary in a prominent place.

Wendy Graf Ray, Research Division, and Amy Compeau, Research Division, contributed significantly to this summary.

(1)

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **Name of Committee**

MAY 21, 2003 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
VANCE C. KINLAW	NC BOARD OF CHIROPRACTIC EXAMINERS
Bill Worthington	Pitt. Co. Winterville, NC.
Bill Whisnant	Town of Winterville
Bill Richardson	City of Greenville
Marvin Davis	City of Greenville
[signature]	NASW
BRIAN LEWIS	Planned Parenthood
SAM SNOWDON	ARCA MENTAL HEALTH
Stana McKinney	NC DHHS
John Cyprus	NC State Change
[signature]	DSC

(2)

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **MAY 21, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Mitchell	NPC
Paul Gonzalez	Tijuana Council
David Barnes	Parry + Spruill LLP
A.J. Horne	NCMS
G Ramquist	NCNP
Marti Ball	Physical Ed. Assoc. High Point Univ. High Point, NC
Roz Savitt	NC Child Care Coalition
June Locklear	DHHS - DCD
Peggy Ball	"
[illegible]	[illegible]
[illegible]	NCIEA

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **MAY 21, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rick Colton	Caldwell Woods PLLC
John Boerstler	Asta Zeneca
Sue-Ann Lee	NCPA
Peg O'Connell	MRNC
Allen Graff	Mayor Town of Highlands

(3)

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **MAY 21, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	Avantis

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 28, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

	BILL NO.	SHORT TITLE	SPONSOR
•	HB 478	Amber Alert	Rep. Decker Rep. Rapp
•	SB 672	Strengthen Public Health Infrastructure	Sen. Hartsell

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 28, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday May 28, 2003, in Room 544, Legislative Office Building. Eleven members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator William Purcell, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Bingham recognized Rep. Decker to explain his bill, HB 478, ***Amber Alert***, to the Committee. Rep. Decker stated that he and Rep. Rapp did this bill together and they are presenting it as a team. They put this bill in after the little girl was adducted in Virginia last year and her remains were eventually found in North Carolina. At that time it was found that NC had a voluntary system with only about 14 counties participating, therefore they felt it should go state wide. The NC center for missing persons had created a program called NC Can, which stood for NC Child Alert Notification System. Their criteria was used for the identification of missing children which was put into law, however they changed the age from twelve to seventeen and under. Rep. Decker called on Rep. Rapp.

For technical purposes Senator Bingham requested a motion to waive the rules to consider the PCS. Senator Reeves and Senator Dannley made the motion which carried.

Rep. Rapp was recognized to speak on the bill. He pointed out that the Senate has already passed this bill unanimously. It was Senator Queen's bill. Senator Dannley asked about a fiscal note and where it goes from here. Senator Bingham stated the bill goes directly to the floor. Senator Dannley moved for a favorable report for the Proposed Committee Substitute, unfavorable to the original bill. Senator Metcalf stated that he wanted to thank Rep. Deck and Rep. Rapp and Senator Queen. The motion carried unanimously.

Senator Bingham requested a motion to waive the rule to consider the Proposed Committee Substitute for SB 672, ***Strengthen Public Health Infrastructure***, which was made by Senator Reeves. The motion carried. Senator Hartsell was recognized to explain the bill and PCS. Sen. Hartsell begin with a background for the bill stating this bill is a labor of love of three people. John Shaw, a retired health director, Linda Attarian, Research Staff, and himself, Senator Hartsell. This bill is the end product of our work with The National Public Health Leadership Institute, which is an organization that is put together with leadership teams from public health from all over the country, who discuss different issues and have certain projects and plans. It is located in Chapel Hill and is now a two year program. This is their project for year eleven. Our project was simply to develop a plan for restructuring public health and its delivery system in NC in a fashion consistent with the growing nature of the state. There is a hand out, National Public Health leadership proposal and Senate Bill 672, (attached) telling how they got where they are now. There is also another hand out, NC Public Health Studies and Reports, (attached) which identifies a series of eight different studies that have been undertaken in the state of NC over the last approximately ten years looking at the public health system, the delivery, and so forth, with a number of recommendation. They were done by various groups over time and fortunately or unfortunately very little if anything have been done as the results of these studies. So they went through those studies and there were certain engaging facts they learned. One of which, based on certain fundamental areas of health involving various standards, there are wide disparities in NC relating to the quality of health care delivery, basically what our status is. What they want to do is to try to focus on this and to address this to some extent. We also learned interestingly enough over the last ten years there has been an increasing amount of money that has actually gone into public health through the system, most of this money having come from Medicaid. There have been some expansion of delivery, but in all candor, it appears that with the expansion of the access system which we know, is a system that calls for the collaboration of the various health care entities; health departments, clinics, and all sorts of activities. It appears that source of funding is drying up, maybe that is not right, but it gets shifted as a result. That is an increasing fact away from public health which in effect results in a decrease in our ability to provide some basic care because we do not have the financial basis available in many areas of the state. There was a national study called The Turning Point Initiative that was headed by a professor out of George Town, who has a join appointment George Town Law and John Hopkins Public Health who developed a model public health organizational structure for the country. They

tried to take the facts they learned and put them together in a fashion that is consistent and tailored with NC. The bill sets certain standards. This is what we expect in terms of public health in the state. It calls upon local folks to come up with plans to meet those standards and basically strategic plans which are very common in most other areas over about a five year period. It also calls upon the state to do the same and to mesh those plans. It further more calls upon the locals in the state to come up with a plan for accreditation that meshes with those standards so that we have accountability, a way to proceed, hopefully in corporation with private contractors coming together in a focused way to meet the needs of the public health needs as a whole. The bill is not prescriptive in the terms of how you get there. It is prescriptive only in the sense that it calls upon locals and the state to come up with plans that get us there. The intent of the bill is to create a mechanism whereby the folks that are in the field can come together and work up plans in a significant way for the betterment of the people of this state as a whole.

Senator Bingham asked if any committee members had any questions. Senator Forrestor supports the bill, but had a question on page 11 lines 1-6 and 31-33 both talk about modifying the structure and implementing public health infrastructure reform, do some local health departments feel threatened about this? Sen. Hartsell's answer was yes. Senator Forrestor also asked about the last section where it talks about a million dollars for counties to consolidate into multi-county district health departments and he wanted to know if it has to go to Appropriations. This bill does have to go to Appropriations. Senator Queen stated it looks like a very good bill, certainty very sweeping and important intent, before we get done today he would like for his local health department director from Haywood County, Bob Wood to say a few comments on the bill and ask a few questions. Senator Bingham stated that Debra Rowe , Association of local Health Director, had given him a list of several health directors that are there from several counties to speak.

Senator Kinnard stated there are federal health clinics sprinkled throughout the state. They are funded with federal grants from 30 years ago. They serve a huge population especially our Latino population right now. Would you be drawing them in? Senator Hartsell stated they are part of the delivery system now and they will continue to be part of the delivery system. Staff Sandra Alley pointed out on page 5 lines 1-4 and on page 3 line 22 it speaks about public sector partner which is defined as international, federal, tribal, or other state and local government and their public health agencies so the bill does intend to incorporate federal health agencies.

Senator Hartsell had requested that his co-conspirators who worked on this with him be allowed to speak. Staff Research Linda Attairan and John Shaw, retired local health director both spoke.

Several Local Health Directors addressed the committee beginning with, Jim Ballus, President of NC Association of Local Health Director who is the health director for Edgecombe County. The health director of this state applauded the intentions of this bill, however they have serious concerns about the short time lines in the bill to achieve such major reforms. They recommend to send this bill to a study commission. Other local health directors who spoke were Bob Wood, Health Director for Haywood County who stated they have already started the accreditation process in their county, however, the local partners that they are expected to do business with have not been asked about this process. George Bond, Health Director for Buncombe County feels the main problem is lack of resources. Senator Forrestor made a motion to send the bill on to Appropriation and Senator Dannley seconded.

Ed Regan, NC Association of County Commissioners, had requested to speak. He stated his concern as there were no role mentioned for county commissioner in this bill and for that reason he feels it needs more thorough study. Jerry Parks, Health Director for Albemarle Regional Health Services, who serves six counties in northeastern NC, stated that consolidation is already taking place. It takes time to negotiate a consolidation. Steve Slott, President of The Association of NC Boards of Health, also spoke.

The Co-Chairs, Senator Bingham and Senator Purcell asked that the discussion of Senate Bill 672 continue at another meeting of the Health and Human Resources Committee.

The meeting adjourned.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 28, 2003

SENATOR BINGHAM,
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) **478** Amber Alert.

Draft Number:	PCS45150
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 478

Committee Substitute Favorable 4/2/03

Short Title: Amber Alert. (Public)

Sponsors:

Referred to:

March 13, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE NORTH CAROLINA CHILD ALERT NOTIFICATION (NC CAN) SYSTEM AND TO RENAME THAT SYSTEM THE AMBER ALERT SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-499.1 reads as rewritten:

"**§ 143B-499.1. Dissemination of missing persons data by law-enforcement agencies.**

A law-enforcement agency, upon receipt of a missing person report by a parent, spouse, guardian, or legal custodian, shall immediately make arrangements for the entry of data about the missing person or missing child into the national missing persons file in accordance with criteria set forth by the FBI/NCIC, immediately inform all of its on-duty law-enforcement officers of the missing person report, initiate a statewide broadcast to all appropriate law-enforcement agencies to be on the lookout for the individual, and transmit a copy of the report to the Center.

If the report involves a missing child and the report meets the criteria established in G.S. 143B-499.7(b), as soon as practicable after receipt of the report, the law enforcement agency shall notify the Center and the National Center for Missing and Exploited Children of the relevant data about the missing child."

SECTION 2. G.S. 143B-499.2 reads as rewritten:

"**§ 143B-499.2. Responsibilities of Center.**

The Center shall:

(1) Assist local law-enforcement agencies with entering data about missing persons or missing children into the national missing persons file, ensure that proper entry criteria have been met as set forth by the FBI/NCIC, and confirm entry of the data about the missing persons or missing children;

(2) Gather and distribute information and data on missing children and missing persons;

(3) Encourage research and study of missing children and missing persons, including the prevention of child abduction and the prevention of the exploitation of missing children;

(4) Serve as a statewide resource center to assist local communities in programs and initiatives to prevent child abduction and the exploitation of missing children;

(5) Continue increasing public awareness of the reasons why children are missing and vulnerability of missing children;

(6) Achieve maximum cooperation with other agencies of the State, with agencies of other states and the federal government and with the National Center for Missing and Exploited Children in rendering assistance to missing children and missing persons and their parents, guardians, spouses, or legal custodians; and cooperate with interstate and federal efforts to identify deceased individuals;

(6a) Develop and maintain the ~~North Carolina Child Alert Notification System (NC CAN)~~ AMBER Alert System as created by G.S. 143B-499.7;

(7) Forward the appropriate information to the Police Information Network to assist it in maintaining and publishing a bulletin of currently missing children and missing persons;

(8) Maintain a directory of existing public and private agencies, groups, and individuals that provide effective assistance to families in the areas of prevention of child abduction, location of missing children and missing persons, and follow-up services to the child or person and family, as determined by the Secretary of Crime Control and Public Safety;

(9) Annually compile and publish reports on the actual number of children and persons missing each year, listing the categories and causes, when known, for the disappearances;

(10) Provide follow-up referrals for services to missing children or persons and their families;

(11) Maintain a toll-free 1-800 telephone service that will be in service at all times; and

(12) Perform such other activities that the Secretary of Crime Control and Public Safety considers necessary to carry out the intent of its mandate."

SECTION 3. G.S. 143B-499.7 reads as rewritten:

"**§ 143B-499.7. North Carolina Child Alert Notification System established.**

(a) There is established within the North Carolina Center for Missing Persons the ~~North Carolina Child Alert Notification System (NC CAN).~~ AMBER Alert System. The purpose of ~~NC CAN~~ AMBER Alert is to provide a statewide system for the rapid dissemination of information regarding abducted children.

(b) The ~~NC CAN~~ AMBER Alert System shall make every effort to disseminate information on missing children as quickly as possible when the following criteria are met:

(1) The child is ~~12~~17 years of age or younger;

~~(2) The child is believed to have been abducted;~~

~~(3) The child is believed to be in danger of injury or death;~~

(2) The child is believed:

a. To have been abducted, or

b. To be in danger of injury or death;

~~(4)~~(3) The abduction is not known or suspected to be by a parent of the ~~child;~~ child, unless the child's life is suspected to be in danger;

~~(5)~~(4) The child is not believed to be a runaway or voluntarily missing; and

~~(6)~~(5) The abduction has been reported to and investigated by a law enforcement agency.

~~The NC CAN System may disseminate information on missing children who are ages 13 to 17 on a case-by-case basis, if all other criteria in subdivisions (2) through (6) of this subsection have been met, if the Center believes the dissemination of the information to be beneficial in the possible recovery of the missing child.~~

If the abduction of the child is known or suspected to be by a parent of the child, the Center, in its discretion, may disseminate information through the ~~NC CAN~~ AMBER Alert System if the child is believed to be in danger of injury or death.

(c) The Center shall adopt guidelines and develop procedures for the statewide implementation of the ~~NC CAN~~ AMBER Alert System and shall provide education and training to encourage radio and television broadcasters to participate in the System. The Center shall work with the Department of Justice in developing training material regarding the ~~NC CAN~~AMBER Alert System for law enforcement, broadcasters, and community interest groups.

(d) The Center shall consult with the Department of Transportation and develop a procedure for the use of overhead permanent changeable message signs to provide information on the abduction of a child meeting the criteria established in subsection (b) of this section, when information is available that would enable motorists to assist law enforcement in the recovery of the missing child. The Center and the Department of Transportation shall develop guidelines for the content, length, and frequency of any message to be placed on an overhead permanent changeable message sign.

(e) The Center shall consult with the Division of Emergency Management, in the Department of Crime Control and Public Safety, to develop a procedure for the use of the Emergency Alert System to provide information on the abduction of a child meeting the criteria established in subsection (b) of this section.

(f) The Department of Crime Control and Public Safety, on behalf of the Center, may accept grants, contributions, devises, bequests, and gifts, which shall be kept in a separate fund, which shall be nonreverting, and shall be used to fund the operations of the Center and the ~~NC CAN~~ AMBER Alert System."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 478

Committee Substitute Favorable 4/2/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H478-CSSW-42 [v.1]

5/22/2003 12:14:25 PM

Short Title: Amber Alert. (Public)

Sponsors:

Referred to:

March 13, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE NORTH CAROLINA CHILD ALERT NOTIFICATION (NC CAN) SYSTEM AND TO RENAME THAT SYSTEM THE AMBER ALERT SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-499.1 reads as rewritten:

"**§ 143B-499.1. Dissemination of missing persons data by law-enforcement agencies.**

A law-enforcement agency, upon receipt of a missing person report by a parent, spouse, guardian, or legal custodian, shall immediately make arrangements for the entry of data about the missing person or missing child into the national missing persons file in accordance with criteria set forth by the FBI/NCIC, immediately inform all of its on-duty law-enforcement officers of the missing person report, initiate a statewide broadcast to all appropriate law-enforcement agencies to be on the lookout for the individual, and transmit a copy of the report to the Center.

If the report involves a missing child and the report meets the criteria established in G.S. 143B-499.7(b), as soon as practicable after receipt of the report, the law enforcement agency shall notify the Center and the National Center for Missing and Exploited Children of the relevant data about the missing child."

SECTION 2. G.S. 143B-499.2 reads as rewritten:

"**§ 143B-499.2. Responsibilities of Center.**

The Center shall:

(1) Assist local law-enforcement agencies with entering data about missing persons or missing children into the national missing persons file, ensure that proper entry criteria have been met as set forth by the FBI/NCIC, and confirm entry of the data about the missing persons or missing children;

(2) Gather and distribute information and data on missing children and missing persons;

(3) Encourage research and study of missing children and missing persons, including the prevention of child abduction and the prevention of the exploitation of missing children;

(4) Serve as a statewide resource center to assist local communities in programs and initiatives to prevent child abduction and the exploitation of missing children;

(5) Continue increasing public awareness of the reasons why children are missing and vulnerability of missing children;

(6) Achieve maximum cooperation with other agencies of the State, with agencies of other states and the federal government and with the National Center for Missing and Exploited Children in rendering assistance to missing children and missing persons and their parents, guardians, spouses, or legal custodians; and cooperate with interstate and federal efforts to identify deceased individuals;

(6a) Develop and maintain the ~~North Carolina Child Alert Notification System (NC CAN)~~ AMBER Alert System as created by G.S. 143B-499.7;

(7) Forward the appropriate information to the Police Information Network to assist it in maintaining and publishing a bulletin of currently missing children and missing persons;

(8) Maintain a directory of existing public and private agencies, groups, and individuals that provide effective assistance to families in the areas of prevention of child abduction, location of missing children and missing persons, and follow-up services to the child or person and family, as determined by the Secretary of Crime Control and Public Safety;

(9) Annually compile and publish reports on the actual number of children and persons missing each year, listing the categories and causes, when known, for the disappearances;

(10) Provide follow-up referrals for services to missing children or persons and their families;

(11) Maintain a toll-free 1-800 telephone service that will be in service at all times; and

(12) Perform such other activities that the Secretary of Crime Control and Public Safety considers necessary to carry out the intent of its mandate."

SECTION 3. G.S. 143B-499.7 reads as rewritten:

"**§ 143B-499.7. North Carolina ~~Child Alert Notification~~ AMBER Alert System established.**

(a) There is established within the North Carolina Center for Missing Persons the ~~North Carolina Child Alert Notification System (NC CAN).~~ AMBER Alert System. The

purpose of ~~NC CAN~~ AMBER Alert is to provide a statewide system for the rapid dissemination of information regarding abducted children.

(b) The ~~NC CAN~~ AMBER Alert System shall make every effort to disseminate information on missing children as quickly as possible when the following criteria are met:

(1) The child is ~~12~~ 17 years of age or younger;

~~(2) The child is believed to have been abducted;~~

~~(3) The child is believed to be in danger of injury or death;~~

(4) The abduction is not known or suspected to be by a parent of the ~~child;~~ child, unless the child's life is suspected to be in danger of injury or death;

(4a) The child is believed:

a. To have been abducted, or

b. To be in danger of injury or death;

(5) The child is not a runaway or voluntarily missing; and

(6) The abduction has been reported to and investigated by a law enforcement agency.

~~The NC CAN System may disseminate information on missing children who are ages 13 to 17 on a case-by-case basis, if all other criteria in subdivisions (2) through (6) of this subsection have been met, if the Center believes the dissemination of the information to be beneficial in the possible recovery of the missing child.~~

If the abduction of the child is known or suspected to be by a parent of the child, the Center, in its discretion, may disseminate information through the ~~NC CAN~~ AMBER Alert System if the child is believed to be in danger of injury or death.

(c) The Center shall adopt guidelines and develop procedures for the statewide implementation of the ~~NC CAN~~ AMBER Alert System and shall provide education and training to encourage radio and television broadcasters to participate in the System. The Center shall work with the Department of Justice in developing training material regarding the ~~NC CAN~~AMBER Alert System for law enforcement, broadcasters, and community interest groups.

(d) The Center shall consult with the Department of Transportation and develop a procedure for the use of overhead permanent changeable message signs to provide information on the abduction of a child meeting the criteria established in subsection (b) of this section, when information is available that would enable motorists to assist law enforcement in the recovery of the missing child. The Center and the Department of Transportation shall develop guidelines for the content, length, and frequency of any message to be placed on an overhead permanent changeable message sign.

(e) The Center shall consult with the Division of Emergency Management, in the Department of Crime Control and Public Safety, to develop a procedure for the use of the Emergency Alert System to provide information on the abduction of a child meeting the criteria established in subsection (b) of this section.

(f) The Department of Crime Control and Public Safety, on behalf of the Center, may accept grants, contributions, devises, bequests, and gifts, which shall be kept in a

separate fund, which shall be nonreverting, and shall be used to fund the operations of the Center and the ~~NC CAN~~ AMBER Alert System."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 478

Committee Substitute Favorable 4/2/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H478-PCS45150-SW-42

Short Title: AMBER Alert. (Public)

Sponsors:

Referred to:

March 13, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE NORTH CAROLINA CHILD ALERT NOTIFICATION (NC CAN) SYSTEM AND TO RENAME THAT SYSTEM THE AMBER ALERT SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-499.1 reads as rewritten:

"**§ 143B-499.1. Dissemination of missing persons data by law-enforcement agencies.**

A law-enforcement agency, upon receipt of a missing person report by a parent, spouse, guardian, or legal custodian, shall immediately make arrangements for the entry of data about the missing person or missing child into the national missing persons file in accordance with criteria set forth by the FBI/NCIC, immediately inform all of its on-duty law-enforcement officers of the missing person report, initiate a statewide broadcast to all appropriate law-enforcement agencies to be on the lookout for the individual, and transmit a copy of the report to the Center.

If the report involves a missing child and the report meets the criteria established in G.S. 143B-499.7(b), as soon as practicable after receipt of the report, the law enforcement agency shall notify the Center and the National Center for Missing and Exploited Children of the relevant data about the missing child."

SECTION 2. G.S. 143B-499.2 reads as rewritten:

"**§ 143B-499.2. Responsibilities of Center.**

The Center shall:

(1) Assist local law-enforcement agencies with entering data about missing persons or missing children into the national missing persons file, ensure that proper entry criteria have been met as set forth by the FBI/NCIC, and confirm entry of the data about the missing persons or missing children;

(2) Gather and distribute information and data on missing children and missing persons;

(3) Encourage research and study of missing children and missing persons, including the prevention of child abduction and the prevention of the exploitation of missing children;

(4) Serve as a statewide resource center to assist local communities in programs and initiatives to prevent child abduction and the exploitation of missing children;

(5) Continue increasing public awareness of the reasons why children are missing and vulnerability of missing children;

(6) Achieve maximum cooperation with other agencies of the State, with agencies of other states and the federal government and with the National Center for Missing and Exploited Children in rendering assistance to missing children and missing persons and their parents, guardians, spouses, or legal custodians; and cooperate with interstate and federal efforts to identify deceased individuals;

(6a) Develop and maintain the ~~North Carolina Child Alert Notification System (NC CAN)~~ AMBER Alert System as created by G.S. 143B-499.7;

(7) Forward the appropriate information to the Police Information Network to assist it in maintaining and publishing a bulletin of currently missing children and missing persons;

(8) Maintain a directory of existing public and private agencies, groups, and individuals that provide effective assistance to families in the areas of prevention of child abduction, location of missing children and missing persons, and follow-up services to the child or person and family, as determined by the Secretary of Crime Control and Public Safety;

(9) Annually compile and publish reports on the actual number of children and persons missing each year, listing the categories and causes, when known, for the disappearances;

(10) Provide follow-up referrals for services to missing children or persons and their families;

(11) Maintain a toll-free 1-800 telephone service that will be in service at all times; and

(12) Perform such other activities that the Secretary of Crime Control and Public Safety considers necessary to carry out the intent of its mandate."

SECTION 3. G.S. 143B-499.7 reads as rewritten:

"**§ 143B-499.7. North Carolina ~~Child Alert Notification~~ AMBER Alert System established.**

(a) There is established within the North Carolina Center for Missing Persons the ~~North Carolina Child Alert Notification System (NC CAN).~~ AMBER Alert System. The

purpose of ~~NC-CAN-~~AMBER Alert is to provide a statewide system for the rapid dissemination of information regarding abducted children.

(b) The ~~NC-CAN-~~AMBER Alert System shall make every effort to disseminate information on missing children as quickly as possible when the following criteria are met:

(1) The child is ~~12~~ 17 years of age or younger;

~~(2) The child is believed to have been abducted;~~

~~(3) The child is believed to be in danger of injury or death;~~

(4) The abduction is not known or suspected to be by a parent of the ~~child;~~ child, unless the child's life is suspected to be in danger of injury or death;

(4a) The child is believed:

a. To have been abducted, or

b. To be in danger of injury or death;

(5) The child is not a runaway or voluntarily missing; and

(6) The abduction has been reported to and investigated by a law enforcement agency.

~~The NC-CAN System may disseminate information on missing children who are ages 13 to 17 on a case-by-case basis, if all other criteria in subdivisions (2) through (6) of this subsection have been met, if the Center believes the dissemination of the information to be beneficial in the possible recovery of the missing child.~~

If the abduction of the child is known or suspected to be by a parent of the child, the Center, in its discretion, may disseminate information through the ~~NC-CAN-~~AMBER Alert System if the child is believed to be in danger of injury or death.

(c) The Center shall adopt guidelines and develop procedures for the statewide implementation of the ~~NC-CAN-~~AMBER Alert System and shall provide education and training to encourage radio and television broadcasters to participate in the System. The Center shall work with the Department of Justice in developing training material regarding the ~~NC-CAN~~AMBER Alert System for law enforcement, broadcasters, and community interest groups.

(d) The Center shall consult with the Department of Transportation and develop a procedure for the use of overhead permanent changeable message signs to provide information on the abduction of a child meeting the criteria established in subsection (b) of this section, when information is available that would enable motorists to assist law enforcement in the recovery of the missing child. The Center and the Department of Transportation shall develop guidelines for the content, length, and frequency of any message to be placed on an overhead permanent changeable message sign.

(e) The Center shall consult with the Division of Emergency Management, in the Department of Crime Control and Public Safety, to develop a procedure for the use of the Emergency Alert System to provide information on the abduction of a child meeting the criteria established in subsection (b) of this section.

(f) The Department of Crime Control and Public Safety, on behalf of the Center, may accept grants, contributions, devises, bequests, and gifts, which shall be kept in a

separate fund, which shall be nonreverting, and shall be used to fund the operations of the Center and the ~~NC CAN~~ AMBER Alert System."

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

HOUSE BILL 478:
Amber Alert

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Reps. Decker and Rapp
		Summary by:	Dianna Jessup Committee Counsel
Date:	May 28, 2003		
Version:	PCS H478-CSSW-42		

SUMMARY: ***House Bill 478 would rename the North Carolina Child Alert Notification System as the AMBER Alert System. It would require law enforcement to send notice of missing children to the National Center for Missing and Exploited Children, and would make changes to the criteria that will determine when an AMBER Alert is triggered. The act would become effective when it becomes law.***

The PCS makes technical changes to the bill.

CURRENT LAW: Chapter 143B of the General Statutes, in Article 11, Part 5A, provides for establishment of the North Carolina Center for Missing Persons within the Department of Crime Control and Public Safety. The Center serves as a central repository for information regarding missing persons and missing children, with special emphasis on missing children. Upon receipt of a missing person report by a parent, spouse, guardian or legal custodian, a law enforcement agency provides for the entry of data about the missing person into the national missing persons file in accordance with criteria set forth by the Federal Bureau of Investigation/National Crime Information Center. The North Carolina Child Alert Notification System (NC CAN) provides a statewide system for the rapid dissemination of information regarding abducted children. When a law-enforcement agency receives a missing person report involving a child 12 years of age or younger, and the child is believed to have been abducted and in danger of injury or death, the NC Can System is required to make every effort to disseminate information on that missing child. On a case-by-case basis, when other criteria are met, NC CAN may disseminate information regarding missing children who are ages 13 to 17. The Center for Missing Persons has statutory authority to adopt guidelines and develop procedures for statewide implementation of the NC CAN System, including education and training to encourage radio and television broadcasters to participate in the System, and development of a plan in cooperation with the Department of Transportation to use overhead changeable highway message signs to provide information regarding the abducted child to motorists.

BILL ANALYSIS: ***Section 1*** of the bill would provide that when a law enforcement agency receives a missing person report involving a child, and the report meets the criteria governing the AMBER Alert System, the law enforcement agency must notify the National Center for Missing and Exploited Children as well as the North Carolina Center for Missing Persons. The National Center for Missing and Exploited Children is a private, nonprofit agency that serves as a focal point in providing assistance to parents, children, law enforcement, schools, and the community in recovering missing children and raising public awareness about ways to help prevent child abduction, molestation, and sexual exploitation.

Section 2 of the bill would direct the North Carolina Center for Missing Persons within the Department of Crime Control and Public Safety to develop and maintain the AMBER Alert System (currently known as NC CAN).

Section 3 of the bill would change statutory references to NC CAN by substituting AMBER Alert. This section of the bill would also amend the criteria for AMBER Alert to raise the age limit from 12 to 17

years and eliminate the language that provides that information regarding children age 13 to 17 may be disseminated through the system as determined on a case-by-case basis.

Section 4 would provide that the bill would be effective when it becomes law.

BACKGROUND: According to information available from the National Center for Missing & Exploited Children (NCMEC), the AMBER Plan was created in 1996 as a legacy to 9-year-old Amber Hagerman, who was kidnapped and brutally murdered while riding her bicycle in Arlington, Texas. In the Fall of 2001 the NCMEC launched the AMBER Plan - America's Missing: Broadcast Emergency Response nationwide.

Once law enforcement has been notified about an abducted child, they must first determine if the case meets the AMBER Plan's criteria for triggering an alert. Each program establishes its own AMBER Plan criteria; however, the National Center for Missing & Exploited Children suggests three criteria that should be met before an Alert is activated.

- law enforcement confirms a child has been abducted
- law enforcement believes the circumstances surrounding the abduction indicate that the child is in danger of serious bodily harm or death
- there is enough descriptive information about the child, abductor, and/or suspect's vehicle to believe an immediate broadcast alert will help

If these criteria are met, alert information must be put together for public distribution. This information can include descriptions and pictures of the missing child, the suspected abductor, a suspected vehicle, and any other information available and valuable to identifying the child and suspect.

The information is then faxed to radio stations designated as primary stations under the Emergency Alert System (EAS). The primary stations send the same information to area radio and television stations and cable systems via the EAS, and it is immediately broadcast by participating stations to potentially millions of listeners. Radio stations interrupt programming to announce the Alert, and television stations and cable systems run a "crawl" on the screen along with a picture of the child.

Some states are also incorporating electronic highway billboards in their Plans. The billboards, typically used to disseminate traffic information to drivers, now alert the public of abducted children, displaying pertinent information about the child, abductor or suspected vehicle that drivers might look for on highways.

(Source: National Center for Missing & Exploited Children at http://www.missingkids.com)

Brenda Carter, staff attorney, substantially contributed to this summary.

H478-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 672

Short Title:	Strengthen Public Health Infrastructure.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Health & Human Resources.	

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT OF STATE AND LOCAL COMPREHENSIVE PUBLIC HEALTH PLANS, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE BY ENHANCING COLLABORATION WITH PUBLIC AND PRIVATE SECTOR ENTITIES AND IMPOSING PERFORMANCE STANDARDS FOR PUBLIC HEALTH PRACTICE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure;

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions;

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies, the collaboration of the public and private sectors within the public health system, and the consolidation of local public health agencies;

Whereas, a consensus for establishing, prioritizing and implementing essential public health services and functions can be achieved through locally developed and coordinated health plans that provide the foundation for a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 is repealed.

SECTION 2. G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-1.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6aa) "Local public health agency" means a local health director, a local board of health, and a local health department.

(6a) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency and are identified in the local public health plans in accordance with G.S. 130A-2.7.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, tribal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(8b) "Tribe" means the same as the term 'Indian Tribe' in 25 U.S.C. § 450b(e), section 4(e) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

(8c) "Tribal public health agency" means any program or organization operated by a tribe or tribal organization, including boards, agencies, commissions, or offices, that principally acts or is responsible to protect or preserve the public's health and shall include the health programs of any tribal organization that carries out essential public health services and functions or otherwise acts to protect or preserve the public health.

(8d) "Tribal organization" means the same as the term in 25 U.S.C. § 450b(l), section 4(l) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 3. Part 1 of Article 1 of Chapter 130A is amended by adding the following new sections to read:

"**§ 130A-2.1. Mission statement.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The mission of the State and local public health agencies is to provide leadership and protect and promote the public's health by:

(1) Providing essential public health services and functions as provided in G.S. 130A-1.3.

(2) Encouraging collaboration among public and private sector partners in the public health system.

(3) Seeking adequate funding to provide essential public health services and functions and to accomplish public health goals from public or private sources.

(c) Nothing in this section shall be construed to require the State or local public health agencies or an individual or agency within the public health system to provide specific health services or to implement unfunded programs.

"**§ 130A-2.2. Responsibilities of State and local governments; private sector collaboration.**

(a) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(b) State and local public health agencies shall collaborate with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-33-55.

(d) State or local public health agencies may contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through these private sector entities if:

(1) The contractor has the potential to improve public health outcomes without causing harm to individuals or the public health system.

(2) Privatized services are fully and regularly monitored by the contracting public health agency or others within the public health system. Nothing is this subdivision shall be construed to require private sector entities to be monitored by other public agencies providing services within the public health system. The State public health agency shall devise, in consultation with others within the public health system, evaluation criteria to be used in conducting performance reviews of any private sector partner that provides privatized services or functions.

(3) Privatized services or functions are subject to other federal, State, or local laws.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies, in collaboration with public and private sector partners, shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Diagnose and investigate health problems and health hazards in the community.

(3) Inform people about health issues.

(4) Develop policies and plans that support individual and community health efforts.

(5) Enforce laws and regulations that protect health and ensure safety.

(6) Link individuals to needed personal health services and facilitate the provision of health care when not otherwise available.

(7) Monitor and ensure the competency of the public health workforce.

(8) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(9) Conduct research to identify new insights and innovative solutions to health problems.

(10) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(11) When not otherwise available through the private sector, collaborate with other public sector partners to promote the availability of and access to preventive and primary health care, including acute and episodic care, prenatal and postpartum care, child health, family

planning, school health, chronic disease preventions, child and adult immunization, dental health, nutrition, and health education and promotion services.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, or the Department of Environment and Natural Resources as otherwise conferred by State law.

"**§ 130A-2.4. Public health infrastructure.**

(a) The Secretary shall coordinate State and local public health agencies and their public and private sector partners to do the following to strengthen and maintain stability of the public health infrastructure:

(1) Identify and provide leadership for the provision of essential public health services and functions;

(2) Develop management standards for the public health system and workforce that are tied to improvements in public health outcomes or other measures;

(3) Develop and provide effective training for members of the public health workforce that is focused on performance-based standards;

(4) Evaluate performance management standards and training efforts within the public health system; and

(5) Comprehensively plan and set priorities for the efficient and effective accomplishment of essential public health services and functions.

(b) In performing the duties set forth in subsection (a) of this section, State and local public health agencies and their public and private sector partners shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

"**§ 130A-2.5. Public health workforce.**

(a) The State public health agency shall manage the public health workforce performance related to public health infrastructure and capacity, processes, and outcomes at the State and local levels. The State public health agency shall establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These include the following:

(1) Performance measurement standards for the public health system. – Consistent with the National Public Health Performance Standards Program, the State public health agency shall adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(2) Accreditation of local public health agencies. – The State public health agency shall adopt and administer a mandatory accreditation program for local public health agencies. The accreditation program shall be based on criteria developed by the State public health agency that

focus on the ability of agencies to provide essential public health services and functions.

(3) Certification or credentialing for the public health workforce. – Consistent with any national system of public health workforce certification or credentialing, the State public health agency shall adopt and administer public health workforce certification or credentialing programs for members of the public health workforce. These programs shall be designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas and must be based on:

a. Basic, core, or technical competencies for public health workers; or

b. Professional codes for public health professionals.

(b) The State public health agency shall, directly or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

(c) The State public health agency may require individuals within the public health system to meet minimal training requirements to assist the individual in providing essential public health services and functions.

(d) The State public health agency may provide incentives to meet performance management or training requirements, including:

(1) Organizational accountability awards.

(2) Accreditation recognition for public health agencies or their contractors or volunteers.

(3) Certification or credentialing titles or recognition for individuals.

(4) Other career development initiatives, including financial benefits.

(e) The State public health agency shall:

(1) Adopt a framework for the evaluation of the performance of the local public health agency workforce.

(2) Develop standards to consistently evaluate the effectiveness and delivery of training programs, continuation education, and other tools.

(3) Consistently evaluate performance management and training programs, continuing education, and other tools pursuant to these frameworks or standards.

"**§ 130A-2.6. Comprehensive public health plan.**

(a) The State public health agency shall develop a comprehensive public health plan ("Plan") that assesses and sets priorities for the State public health system. The State public health agency shall develop the Plan in consultation with representatives from its public and private sector partners and in consideration of local public health plans submitted in accordance with G.S. 130A-2.7. The Plan may rely on existing or available surveillance data or other formation available to the State public health agency, as well as national guidelines or recommendations concerning public health outcomes and improvements. The Plan shall cover five years and shall be reviewed

annually. Future Plans shall be developed every five years. The Plan shall include the following:

(1) Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

(2) Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

(3) Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

(4) Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

(5) Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies and schedules for meeting these goals.

(6) Strategies for coordinating service delivery within the public health system.

(7) Measurable indicators of effectiveness and success.

(8) Identification of public and private sector partners.

(b) The State public health agency shall submit a copy of the comprehensive State public health plan required under this section annually to the Governor and the General Assembly upon its convening or reconvening, including any recommendations for legislative amendments.

"**§ 130A-2.7. Local public health plans.**

(a) Every county, through its local public health agency, shall provide for the development, review, and approval of a local public health plan consistent with the comprehensive State public health plan required under G.S. 130A-5.4. The local public health plan shall address how the local public health agency will coordinate with the State public health agency and others within the public health system to accomplish goal and priorities identified in the comprehensive State public health plan. The local public health plan shall cover five years and shall be reviewed annually. Future plans shall be developed every five years. In addition to the items listed in G.S. 130A-5.4, the local public health plan shall include the following:

(1) Description of the demographics and health indicators of the population being served by the local public health agency.

(2) Description of the numbers and types of professionals in the local public health workforce.

(3) Description of the local public health workforce training needs.

(4) Description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) Description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and are of the highest quality possible.

(6) Description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) Other matters determined by the Secretary to be necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

(b) The local public health plan shall be approved and submitted to the Secretary no later than July 1, 2004.

(c) The State public health agency shall provide technical assistance to local public health agencies that request assistance and shall otherwise work with local public health agencies to generate the plan."

SECTION 4. G.S. 130A-5 reads as rewritten:

"**§ 130A-5. Duties of the Secretary.**

The Secretary shall have the authority:

(1) To enforce the State health laws and the rules of the Commission;

(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish;

(3) To develop and carry out ~~reasonable health programs that may be necessary for the protection and promotion of the public health and the control of diseases.~~ the comprehensive State public health plan pursuant to G.S. 130A-33-58. The Commission is authorized to adopt rules to carry out ~~these programs.~~ the Plan.

(4) To make sanitary and health investigations and inspections;

(5) To investigate occupational health hazards and occupational diseases and to make recommendations for the elimination of the hazards and diseases. The Secretary shall work with the Industrial Commission and shall file sufficient reports with the Industrial Commission to enable it to carry out all of the provisions of the Workers' Compensation Act with respect to occupational disease.

(6) To receive donations of money, securities, equipment, supplies, realty or any other property of any kind or description which shall be used by the Department for the purpose of carrying out its public health programs;

(7) To acquire by purchase, devise or otherwise in the name of the Department equipment, supplies and other property, real or personal, necessary to carry out the public health programs;

(8) To use the official seal of the Department. Copies of documents in the possession of the Department may be authenticated with the seal of the Department, attested by the signature or a facsimile of the signature of the Secretary, and when authenticated shall have the same evidentiary value as the originals;

(9) To disseminate information to the general public on all matters pertaining to public health; to purchase, print, publish, and distribute free, or at cost, documents, reports, bulletins and health informational materials. Money collected from the distribution of these materials shall remain in the Department to be used to replace the materials;

(10) To be the health advisor of the State and to advise State officials in regard to the location, sanitary construction and health management of all State institutions; to direct the attention of the State to health matters which affect the industries, property, health and lives of the people of the State; to inspect at least annually State institutions and facilities; to make a report as to the health conditions of these institutions or facilities with suggestions and recommendations to the appropriate State agencies. It shall be the duty of the persons in immediate charge of these institutions or facilities to furnish all assistance necessary for a thorough inspection;

(11) To establish a schedule of fees based on income to be paid by a recipient for services provided by Migrant Health Clinics and Development Evaluation Centers;

(12) To establish fees for the sale of specimen containers, vaccines and other biologicals. The fees shall not exceed the actual cost of such items, plus transportation costs;

(13) To establish a fee to cover costs of responding to requests by employers for industrial hygiene consultation services and occupational consultation services. The fee shall not exceed two hundred dollars ($200.00) per on site inspection; ~~and~~

(14) To establish a fee for companion animal certificate of examination forms to be distributed, upon request, by the Department to licensed veterinarians. The fee shall not exceed the cost of the form and shipping ~~costs.~~costs;

(15) Conduct performance management and training programs and evaluations to improve the public health system and workforce; and

(16) Systematically review, on at least an annual basis, the public health system to recommend modifications in its structure or other features to improve public health outcomes."

SECTION 5. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the comprehensive State public health plan and the local public health plans:

(1) Develop the State comprehensive public health plan in accordance with G.S. 130A-5.2 not later than January 1, 2005.

(2) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary and identify rules that are inconsistent with this act.

(3) Review all oversight and monitoring functions currently implemented by the Department with respect to the public health system to determine the effectiveness of the activities on achieving the intent of the act; and improve the oversight and monitoring functions and activities, if necessary; identify areas where additional training is needed and provide it.

(4) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(5) Develop format and required content for local public health plans.

(6) Develop a method for Departmental evaluation of local public health plans.

(7) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health plans.

(8) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement public health infrastructure reform no later than October 1, 2003.

(9) Develop a consolidation plan that will result in no less than 10 and no more than 20 local public health agencies by January 1, 2005.

SECTION 6. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one million dollars ($1,000,000) for the 2003-2004 fiscal year. These funds shall be used to create incentives for counties to consolidate public health services into multicounty district health departments.

SECTION 7. Section 6 of this act becomes effective July 1, 2003. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 672
PROPOSED COMMITTEE SUBSTITUTE S672-CSSP-8 [v.3]

5/27/2003 1:33:11 PM

Short Title: Strengthen Public Health Infrastructure. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT OF STATE AND LOCAL COMPREHENSIVE PUBLIC HEALTH PLANS, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE BY ENHANCING COLLABORATION WITH PUBLIC AND PRIVATE SECTOR ENTITIES AND IMPOSING PERFORMANCE STANDARDS FOR PUBLIC HEALTH PRACTICE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure;

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions;

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies, the collaboration of the public and private sectors within the public health system, and the consolidation of local public health agencies;

Whereas, a consensus for establishing, prioritizing and implementing essential public health services and functions can be achieved through locally developed and coordinated health plans that provide the foundation for a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 is repealed.

SECTION 2. G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-2.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6aa) "Local public health agency" means a local health director, a local board of health, and a local health department.

(6a) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency and are

identified in the local public health plans in accordance with G.S. 130A-2.7.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that

the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 3. Part 1 of Article 1 of Chapter 130A is amended by adding the following new sections to read:

"**§ 130A-2.1. Mission statement.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The mission of the State and local public health agencies is to provide leadership and protect and promote the public's health by:

(1) Providing essential public health services and functions as provided in G.S. 130A-2.3.

(2) Encouraging collaboration among public and private sector partners in the public health system.

(3) Seeking adequate funding to provide essential public health services and functions and to accomplish public health goals from public or private sources.

"**§ 130A-2.2. Responsibilities of State and local governments; private sector collaboration.**

(a) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(b) State and local public health agencies shall collaborate with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-2.3.

(c) State or local public health agencies may contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through these private sector entities if:

(1) The contractor has the potential to improve public health outcomes without causing harm to individuals or the public health system.

(2) Contracted services are fully and regularly monitored by the contracting public health agency. The State and local public health agencies shall devise, in consultation with others within the public health system, evaluation criteria to be used in conducting performance reviews of any private sector partner that provides contracted services or functions.

(3) Contracted services or functions are subject to other federal, State, or local laws.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies, in collaboration with public and private sector partners, shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Mobilize public and private sector collaboration and action to identify and solve health problems.

(3) Diagnose and investigate health problems and health hazards in the community.

(4) Inform people about health issues.

(5) Develop policies and plans that support individual and community health efforts.

(6) Enforce laws and regulations that protect health and ensure a safe and healthful environment.

(7) Promote access to and availability of needed personal health care services and collaborate with other public and private sector partners to promote or provide preventative and primary health care services according to identified community needs. For the purposes of this subdivision preventative and primary health care services include acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, dental health, nutrition, and health education and promotion services.

(8) Monitor and ensure the competency of the public health workforce.

(9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(10) Conduct research to identify new insights and innovative solutions to health problems.

(11) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(12) Establish and maintain an effective public health preparedness and response capacity for all hazards.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, rules adopted by local boards of health, or the Department of Environment and Natural Resources as otherwise conferred by State law.

"**§ 130A-2.4. Public health infrastructure.**

(a) The Secretary shall coordinate State and local public health agencies and their public and private sector partners to do the following to strengthen and maintain stability of the public health infrastructure:

(1) Identify and provide leadership for the provision of essential public health services and functions;

(2) Develop management standards for the State and local public health workforce that are tied to improvements in public health outcomes or other measures;

(3) Develop and provide effective training for members of the State and local public health workforce that is focused on performance-based standards;

(4) Evaluate performance management standards and training efforts within the state and local public health agencies; and

(5) Comprehensively plan and set priorities for the efficient and effective accomplishment of essential public health services and functions.

(b) In performing the duties set forth in subsection (a) of this section, State and local public health agencies shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

"**§ 130A-2.5. Public health workforce.**

(a) The State public health agency shall manage the State and local public health workforce performance related to public health infrastructure and capacity, processes, and outcomes at the State and local levels. The State public health agency shall establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These include the following:

(1) Performance measurement standards for the public health system. – Consistent with the National Public Health Performance Standards Program, the State public health agency shall adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(2) Accreditation of State and local public health agencies. – Not later than January 1, 2005 the State public health agency shall adopt and administer a uniform mandatory accreditation program for all local public health agencies. The accreditation program shall be based on criteria developed by the State public health agency and local public health agencies that focus on the ability of agencies to provide all essential public health services and functions as provided in G.S. 130A-2.3. The State agency will obtain an accreditation directed at the duties and functions of a state level public health agency from a national accrediting body.

(3) Certification or credentialing for the public health workforce. – Consistent with any approved and recognized system of public health workforce certification or credentialing, the State public health agency shall adopt and administer public health workforce certification or credentialing programs for members of the public health agencies. These programs shall be designed to develop knowledge, skills, and

abilities in relevant and contemporary public health practice areas and must be based on:

a. Basic, core, or technical competencies for public health workers; or

b. Professional codes for public health professionals.

(b) The State public health agency shall, directly or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

(c) The State public health agency may require individuals within the public health system to meet minimal training requirements to assist the individual in providing essential public health services and functions.

(d) The State public health agency may provide incentives to meet performance management or training requirements, including:

(1) Organizational accountability awards.

(2) Accreditation recognition for public health agencies or their contractors or volunteers.

(3) Certification or credentialing titles or recognition for individuals.

(4) Other career development initiatives, including financial benefits.

(e) The State public health agency shall:

(1) Adopt a framework for the evaluation of the performance of the local public health agency workforce.

(2) Develop standards to consistently evaluate the effectiveness and delivery of training programs, continuation education, and other tools.

(3) Consistently evaluate performance management and training programs, continuing education, and other tools pursuant to these frameworks or standards.

"**§ 130A-2.6. Local public health plans.**

(a) Every county, through its local public health agency, shall provide for the development, review, and approval of a local public health plan consistent with the comprehensive State public health plan required under G.S. 130A-2.7. The local public health plan shall address how the local public health agency will coordinate with the State public health agency and others within the public health system to accomplish goals and priorities identified in the comprehensive State public health plan. The local public health plan shall cover five years and shall be reviewed annually. Future plans shall be developed every five years. In addition to the items listed in G.S. 130A-2.7, the local public health plan shall include the following:

(1) Description of the demographics and health indicators of the population being served by the local public health agency.

(2) Description of the numbers and types of professionals in the local public health workforce.

(3) Description of the local public health workforce training needs.

(4) Description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) Description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and are of the highest quality possible.

(6) Description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) Other matters determined by the Secretary to be necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

(b) The State public health agency shall provide technical assistance to local public health agencies that request assistance and shall otherwise work with local public health agencies to generate the plan."

"**§ 130A-2.7. Comprehensive State public health plan.**

(a) The State public health agency shall develop a comprehensive public health plan ("Plan") that assesses and sets priorities for the State public health system based on local public health plans developed and submitted in accordance with G.S. 130A-2.6. The State public health agency shall develop the Plan in consultation with representatives from its public and private sector partners. The Plan may rely on existing or available surveillance data or other information available to the State public health agency, as well as national guidelines or recommendations concerning public health outcomes and improvements. The Plan shall cover five years and shall be reviewed annually. Future Plans shall be developed every five years. The Plan shall include the following:

(1) Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

(2) Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

(3) Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

(4) Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

(5) Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies and schedules for meeting these goals.

(6) Strategies for coordinating service delivery within the public health system.

(7) Measurable indicators of effectiveness and success.

(8) Identification of public and private sector partners.

(b) The State public health agency shall submit a copy of the comprehensive State public health plan required under this section annually to the Governor and the General Assembly upon its convening or reconvening, including any recommendations for legislative amendments.

SECTION 4. G.S. 130A-5 reads as rewritten:

"**§ 130A-5. Duties of the Secretary.**

The Secretary shall have the authority:

(1) To enforce the State health laws and the rules of the Commission;

(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish;

(3) To develop and carry out ~~reasonable health programs that may be necessary for the protection and promotion of the public health and the control of diseases.~~ the comprehensive State public health plan pursuant to G.S. 130A-2.7. The Commission is authorized to adopt rules to carry out ~~these programs.~~ the Plan.

(4) To make sanitary and health investigations and inspections;

(5) To investigate occupational health hazards and occupational diseases and to make recommendations for the elimination of the hazards and diseases. The Secretary shall work with the Industrial Commission and

shall file sufficient reports with the Industrial Commission to enable it to carry out all of the provisions of the Workers' Compensation Act with respect to occupational disease.

(6) To receive donations of money, securities, equipment, supplies, realty or any other property of any kind or description which shall be used by the Department for the purpose of carrying out its public health programs;

(7) To acquire by purchase, devise or otherwise in the name of the Department equipment, supplies and other property, real or personal, necessary to carry out the public health programs;

(8) To use the official seal of the Department. Copies of documents in the possession of the Department may be authenticated with the seal of the Department, attested by the signature or a facsimile of the signature of the Secretary, and when authenticated shall have the same evidentiary value as the originals;

(9) To disseminate information to the general public on all matters pertaining to public health; to purchase, print, publish, and distribute free, or at cost, documents, reports, bulletins and health informational materials. Money collected from the distribution of these materials shall remain in the Department to be used to replace the materials;

(10) To be the health advisor of the State and to advise State officials in regard to the location, sanitary construction and health management of all State institutions; to direct the attention of the State to health matters which affect the industries, property, health and lives of the people of the State; to inspect at least annually State institutions and facilities; to make a report as to the health conditions of these institutions or facilities with suggestions and recommendations to the appropriate State agencies. It shall be the duty of the persons in immediate charge of these institutions or facilities to furnish all assistance necessary for a thorough inspection;

(11) To establish a schedule of fees based on income to be paid by a recipient for services provided by Migrant Health Clinics and Development Evaluation Centers;

(12) To establish fees for the sale of specimen containers, vaccines and other biologicals. The fees shall not exceed the actual cost of such items, plus transportation costs;

(13) To establish a fee to cover costs of responding to requests by employers for industrial hygiene consultation services and occupational consultation services. The fee shall not exceed two hundred dollars ($200.00) per on site inspection; ~~and~~

(14) To establish a fee for companion animal certificate of examination forms to be distributed, upon request, by the Department to licensed veterinarians. The fee shall not exceed the cost of the form and shipping ~~costs.~~costs;

(15) Conduct performance management and training programs and evaluations to improve the State and local public health and workforce; and

(16) Systematically review, at least ever five years, the public health system to recommend modifications in its structure or other features to improve public health outcomes."

SECTION 5. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the comprehensive State public health plan and the local public health plans:

(1) Ensure that local public health plans required under G.S. 130A-2.6 are completed and submitted no later than January 1, 2004.

(2) Develop the State comprehensive public health plan in accordance with G.S. 130A-5.2 not later than January 1, 2005.

(2) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary and identify rules that are inconsistent with this act.

(3) Review all oversight and monitoring functions currently implemented by the Department with respect to the public health system to determine the effectiveness of the activities on achieving the intent of the act; and improve the oversight and monitoring functions and activities, if necessary; identify areas where additional training is needed and provide it.

(4) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(5) Develop format and required content for local public health plans.

(6) Develop a method for Departmental evaluation of local public health plans.

(7) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health plans.

(8) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement public health infrastructure reform no later than October 1, 2004.

(9) Develop and implement a consolidation plan based on the accreditation criteria developed pursuant to G.S. 130A-2.5 and a local health agency's ability to provide all essential public health services and functions listed in G.S. 130A-2.3 in a financially sustainable manner. The consolidation plan shall be developed no later than January 1, 2005 and shall be fully implemented no later than July 1, 2006.

SECTION 6. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one million dollars ($1,000,000) for the 2003-2004 fiscal year. These funds shall be used to create incentives for counties to consolidate public health services into multicounty district health departments.

SECTION 7. Section 6 of this act becomes effective July 1, 2003. The remainder of this act is effective when it becomes law.

SENATE BILL 672:
Strengthen Public Health Infrastructure

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Senator Hartsell
Date:	May 27, 2003	**Summary by:**	Sandra Alley
Version:	S672-CSSP-8[v.3]		Committee Counsel

SUMMARY: ***SB 672 repeals G.S. 130A-1 and adds new G.S. 130A-2 through –2.7 to (1) declare mission of state and local public health system; (2) specify responsibilities of state and local governments in the delivery of public health services; (3) require collaboration with private sector partners; (4) define essential public health services and functions; (5) specify specific duties of state agencies in improving public health infrastructure and its workforce (including establishment of certification or accreditation programs); (6) require state health agencies and counties to develop comprehensive public health plans, with specific components for the State plan and local plans specified in the bill; (7) requires DHHS to develop and implement a consolidation plan based on accreditation criteria and local health agencies ability to deliver essential health services by Jan. 1, 2005; (8) Appropriates $1 million to DHHS from General Fund for fiscal 2003-04 to provide incentives to local governments to consolidate local health agencies into regional health departments; (9) rewrites G.S. 130A-5(3) to clarify that the Secretary of DHHS is responsible for carrying out the State public health plan.***

Section 6 of this bill becomes effective July 1, 2003. The remainder of the bill becomes effective when it becomes law.

CURRENT LAW: Under G.S. 130A-1.1 the mission of the State public health system is to promote and contribute to the highest levels of health possible for the people of North Carolina by: 1) preventing health risks and disease; 2) Identifying and reducing health risks and diseases; 3) Detecting, investigating, and preventing the spread of disease; 4) Promoting health lifestyles; 5) Promoting a safe and healthful environment; 6) Promoting the availability and accessibility of quality health care services through the private sector; and 7) Providing quality health care services when not otherwise available. G.S. 130A-1.1 defines "essential public health services" as those services that the state shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North Carolina. In addition G.S. 130A-1.1 states that the Departments of Environment and Natural Resources and Health and Human Services shall attempt to ensure that certain essential public health services are available and accessible to all citizens of the state and shall account for the financing of these services which include, generally, 1) Health Support; 2) Environmental Health; and 3) Personal Health.

Local public health services are provided by counties (G.S. 130A-33.51). A county may operate a county health department, establish a consolidated human services agency pursuant to G.S. 153A-77 (Mecklenburg and Wake Counties only), participate in district health department, or contract with the state for the provision of health services.

Currently there are 85 public health departments operating in North Carolina.

BILL ANALYSIS:

Section 1. repeals G.S. 130A-1.1. which contains the current mission statement.

Section 2. adds additional definitions to G.S. 130A-2. The intent of the new sections is to clarify State policy regarding the mission of the public health system, what are "essential public health services and functions", who provides these services and functions, and who is accountable. For example, the new provisions clarify that:

- State and local public health agencies must work in concert with other public agencies and private organizations, institutions, persons, and businesses to protect and promote the public's health.
- The mission of the State and local public health agencies is to (1) provide leadership, (2) provide essential services, (3) encourage collaboration among public and private sector partners, and (4) seek funding from public and private sources.
- State and county governments are responsible for assuring that the State and local public health agencies and their public and private sector partners accomplish the mission of public health.
- Essential services and functions include: monitoring health status of communities, diagnosing and investigating public health problems and hazards, health education, promoting health care access, quality and availability, research, enforcement of public health laws, ensuring workforce competency, and collaborating with public sector partners to promote access to preventive and primary health care.

Section 3.: adds G.S. 130A-2.4 to direct State and local public health agencies to:

- Work with their public and private sector partners to enhance the leadership and organizational management skills of the public health workforce.
- Ensure that the public health workforce receives necessary leadership and management training to enable the workforce to set goals and priorities to effectively accomplish the essential public health services and functions.

Section 3 also adds G.S. 130A-2.5 to direct State public health agency (includes DHHS and the Commission for Health Services) to establish workforce performance standards, including:

- National Public Health Performance Standards.
- Accreditation of local public health agencies (only those agencies capable of providing essential public health services and functions shall be accredited.
- Certification of credentialing of the public health workforce.

The State public health agency is also directed to:

- Make available continuing education programs.
- Provide incentives for the workforce to meet performance standards and training requirements.

Evaluate the performance of the local public health workforce.

Section 3 adds G.S. 130A-2.6 and 130A-2.7 to require State and local public health agencies to develop comprehensive five-year public health plans that assess and set priorities for the public health system.

Key elements include:

- Local plans are developed by county governmental entities, through the local public health agencies and its public and private sector partners.

- Local plans must identify local goals and priorities and be consistent with the State public health plan.
- Local plans must address local needs and how the local agency will be held accountable for providing essential services and functions and expenditures of revenue.
- Local plans must be approved and submitted by July 1, 2004.
- State plan must be developed in consideration of local plans and submitted not later than January 1, 2005. The ***purpose*** of the State plan is to:
    - Identify public health problems, disparities, threats;
    - Identify specific at-risk populations; to set goals for targeting essential public health services and functions;
    - Set goals for increasing the effectiveness and efficiency of the public health system; and
    - Identify public and private sector partners.

- Amends Part 1 of Article 1 of Chapter 130A by adding a public health mission statement that applies to State and local health agencies. The mission statement says the policy of the state is to protect and promote the health of the public to the greatest extent possible.
- States that it is the responsibility of the State and counties to assure the success of public health systems. It also sets up guidelines for State and local government to contract with or otherwise work with the private sector to deliver public health services.
- Outlines the essential public health services and functions that State and local health agencies are expected to provide, in collaboration with public and private sector partners.
- Directs the Secretary of Health and Human Services to coordinate State and local public health agencies and their public and private sector partner to help strengthen and maintain stability of the public health infrastructure.
- Directs the State public health agency to manage the State and local public health workforce performance related to public health infrastructure and capacity, processes, and outcomes and the State and local level.
- Directs the State public health agency to establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. This would include accreditation of local public health agencies and certification of public health workers.
- Directs counties, through their local public health agencies, to set up local public health plans consistent with the State public health plan.
- Directs that State public health agency to develop a comprehensive State public health plan ("the Plan") that assesses and sets priorities for the State public health system based on the local health plans as described above.

Section 4. rewrites G.S. 130A-5(3), which governs the duties of the Secretary of Health and Human Services. Under the revision it is the Secretary's responsibility to develop and carry out the comprehensive State public health plan pursuant to G.S. 130A-2, and the Commission for Health Services is granted rulemaking authority to carry out the Plan.

Section 4. also requires the department to conduct performance management and training programs and evaluations to improve the State and local public health workforce, and to review the public health system

at least every five years to recommend changes in its structure in order to improve public health outcomes.

Section 5. directs the Department of Health and Human Services to develop and implement a consolidation plan based on the accreditation criteria developed pursuant to G.S. 130A-2.5 and a local health agency's ability to provide all essential health services in a financially sustainable manner. The consolidation plan shall be developed no later than January 1, 2005 and shall be fully implemented no later than July 1, 2006.

BACKGROUND:

In the 1990's there was a growing awareness among some public health leaders that significant adjustments were needed in the organization, financing and provision of public health in North Carolina. At least eight major studies were conducted to determine how local public health should adapt to meet the new challenges to protect the public's health.

The studies demonstrated an awareness of the need for change, an ability to bring community leaders together, an ability to focus on solutions rather than problems, and a need to develop action plans. Thus far, no significant actions have taken place as a result of these efforts.

S672-SMSP-001

The National Public Health Leadership Institute
Proposal and Senate Bill 672

The National Public Health Leadership Institute (NPHLI), located in Chapel Hill, North Carolina, is a cooperative entity created by The Center for Creative Leadership, The North Carolina Institute for Public Health - UNC - Chapel Hill School of Public Health, UNC - Kenan-Flagler Business School, and The Centers for Disease Control and Prevention. The Institute's goal is to develop leadership teams and networks throughout the nation. Each year leadership teams of two to four members are selected on a national basis for the two-year program. Linda Attarian, JD, MPH; Fletcher Hartsell, Jr., JD; and John Shaw, MPH; were selected to participate and chose a team project proposal focusing on the future of public health in North Carolina. Highlights of the North Carolina team's activities follow.

- The team met with representatives of DHHS and NCALHD and discussed the potential NPHLI proposal focusing on the future of public health in North Carolina. The team presentation included data on the profound changes in the State's population, economic indicators, the potential impact of Medicaid expenditures on local public health, and the significant health disparities between counties and regions in the State. February 2002.

- The membership of the NCALHD received a presentation on the team's project proposal. April 2002.

- The team received the latest leadership concepts, practices and technologies during a one-week residential retreat at the Paul J. Rizzo Conference Center in Chapel Hill. May 2002.

- Fourteen major components/key questions to be considered in charting the future of public health in North Carolina were shared with DHHS and NCALHD representatives. August and September 2002.

- The major North Carolina public health studies and reports of the 1990's were reviewed along with new data on staffing and funding for local public health. The Public Health Competency Handbook, the Model State Public Health Act, and the Future of the Public's Health in the 21st Century were analyzed. August to December 2002.

- The first draft of the team's proposal was completed. March 2003.

- Senate Bill 672, Strengthen Public Health Infrastructure, addresses issues identified in the team's project proposal. April 2003.

- The team met with representatives of DHHS and NCALHD. May 2003.

- Senate Bill 672 PROPOSED COMMITTEE SUBSTITUTE S672-CSSP-8 [v.1] was proposed to address issues identified by DHHS and NCALHD representatives. May 2003.

- The team attends the Senate Health and Human Resources Committee meeting. May 2003.

North Carolina Public Health Studies and Reports

In the 1990's there was a growing awareness among some public health leaders that significant adjustments were needed in the organization, financing and provision of public health in North Carolina. At least eight major studies were conducted to determine how local public health should adapt to meet the new challenges to protect the public's health.

1. *Recommendations for Public Health in North Carolina – from a Statewide Forum on the Future of Public Health* by UNC School of Public Health 1990.

2. The General Assembly - *Public Health Study Commission Recommendations* reported in 1991.

3. *The Jeralds–Ezzell–Fletcher Health Care Reform Act of 1993.*

4. *Rural and Urban Medically Underserved Areas Committee Report* to the North Carolina Health Planning Commission.

5. The North Carolina Health Planning Commission – *Community Health Districts Committee Report 1994.*

6. *The Voice of Prevention – North Carolina Public Health Under Health System Reform - Legislative Agenda* – 1994-95.

7. *Ad Hoc Task Force on Public Health System – Configurational Options for a Stronger Future in the Managed Care Environment - Final Report* – February 1997.

8. The North Carolina Association of Local Health Directors' Vision Project initiated June 1997 gave birth to *The Future of Public Health in North Carolina* project in April 1998.

The studies demonstrated an awareness of the need for change, an ability to bring community leaders together, an ability to focus on solutions rather than problems, and a need to develop action plans. <u>No significant actions have taken place as a result of all these efforts.</u>

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 28, 2003**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
George Bond	Buncombe County Health Dept 35 Woodfin, Asheville 28801
Deborah Ramey	Assoc of Local Health Directors
Steve Slott	Association North Carolina Boards of Health
Tim Green	Alamance Co. Public Health Dept/ NC Assoc. Local Hlth Directors 319 B Graham Hopedale Rd Burlington NC 27217
Patricia A. Yancey	APPCNC/ACCH
Barry Tutor	HBA of Raleigh/Wake County
Brian Lewis	Planned Parenthood
Ann Crenella	Cabarrus County Building Ind. Assoc.
Holly Blackwelder	Cabarrus Co BId Assoc.
Jerry L. Parks	Albemarle Regional Health Services
Porter	Smith Anderson

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 28, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Carsten	IC
Julie Allen	NC Statewatch
Whitney Obrig	OSBM
James R. Baluss	NC Assoc. of Local Health Directors
Jamie Harrington	DHHS - DPH
Bill Regan	N.C. Assoc. of Co. Commissioners
J. Elaine Russell	Cherokee Co. Hlth. Dir.
Don Yousey	Brunswick Co. Health Director
Louis Latour	Wilson Co. Dept. of Public Health
Bob Wood	Haywood Co. Health Dept.
John Thaw	1146 Westlake Dr. Kannapolis N.C 28081

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 28, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John O'Hale	Gov's Office
John McHugh	Gov office
Joanne Stevens	nursing + NCCHSH
Camille Stell	KCLH
Aileen York	KCLH
[illegible]	DHHS
Rob Lamm	DHHS
Kari Barsness	DENR
Evelyn Hawthorne	DHR
Cass Cover	BPMHL
Angela Horne	NCMS

VISITOR REGISTRATION SHEET

Health and Human Resources — **May 28, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Smith	WCSR
Butch Summers	NCSDA
PDP	
Angie McBride	NC
Bill Scoggin	KCCH
Paul Hogewood	Catawba County / CHA
Anne Wilson	AHA
Paige Johnson	PPNA

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 4, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- HB 152, Unauthorized Meds./Prevent SIDS/Child Care, Rep. Alexander
- HB 1118, Display Fetal Alcohol syndrome Warning Signs, Rep. Alexander.
- SB 602, Controlled Substance/Physician Registration, Sen. Purcell
- HB 852, Organ Donor Org's./Access to DMV Records, Sen. Metcalf
- SB 672, Strengthen Public Health Infrastructure, Sen. Hartsell

III. Other Business

IV. Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 4, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:0 A.M. on Wednesday, June 4, 2003 in Room 544 of the Legislative Office Building. Seven members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Purcell introduced Representative Martha Alexander to present her bill, HB 152, *Unauthorized Meds./Prevent SIDS/Child Care*. Senator Bingham moved to adopt the proposed committee substitute for this bill for purposes of discussion; the motion passed. Senator Hartsell questioned the severities of the penalties outlined in the bill, and Ms. Dianna Jessup responded. Senator Dannelly moved for a favorable report, and the motion passed.

Representative Alexander explained her bill, HB 1118, *Display Fetal Alcohol syndrome Warning Signs*, to the Committee. Senator Dannelly moved for a favorable report. The motion passed and the bill was re-referred to the Finance Committee.

Senator Metcalf presented his bill, SB 852, *Expand Advance Health Care Registry,* to the Committee. Senator Queen moved to adopt the proposed committee substitute for the purpose of discussion; the motion passed. Senator Lucas moved for a favorable report, the motion passed, that the bill was re-referred to the Finance Committee.

Senator Hartsell brought his bill, SB 672, *Strengthen Public Health Infrastructure*, before the Committee. Senator Forrester moved that the proposed committee substitute be adopted for purposes of discussion, the motion passed. Senator Forrester asked if the county commissioners were in support of the bill. Ms. Sandra Alley responded that their comments had been favorable. Mr. Jim Bayless, president of the North Carolina Association of Local Health Directors spoke in favor of the bill. Senator Dannelly moved for a favorable report, and the motion passed.

The meeting adjourned at 11:40 A.M.

William R. Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 04, 2003

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

FAVORABLE

H.B.(CS #1) **1118** Display Fetal Alcohol Syndrome Warning Signs.
Sequential Referral: Finance
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, June 05, 2003

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

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **672** Strengthen Public Health Infrastructure.

Draft Number:	PCS35309
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **852** Expand Advance Health Care Registry.

Draft Number:	PCS40043
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **152** Unauthorized Meds./Prevent SIDS/Child Care.

Draft Number:	PCS60370
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 3

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 1118

Committee Substitute Favorable 4/29/03

Short Title: Display Fetal Alcohol Syndrome Warning Signs. (Public)

Sponsors:

Referred to:

April 10, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE SIGNS TO BE POSTED WARNING OF THE POSSIBLE DANGERS OF CONSUMPTION OF ALCOHOL DURING PREGNANCY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 18B-203(a) is amended by adding the following new subdivision to read:

"(18) Provide for the distribution and posting of warning signs to local ABC boards regarding the dangers of alcohol consumption during pregnancy as required under G.S. 18B-808."

SECTION 2. Article 8 of Chapter 18B of the General Statutes is amended by adding the following new section to read:

"**§ 18B-808. Warning signs regarding dangers of alcohol consumption during pregnancy required; posting.**

(a) Each ABC store shall display or cause to be displayed warning signs that meet the requirements of this section on the store's premises to inform the public of the effects of alcohol consumption during pregnancy.

(b) The Commission shall develop the warning signs in accordance with subsection (c) of this section and provide for their distribution and replacements to local ABC boards subject to the requirement of this section. The Commission may charge a reasonable fee, not to exceed twenty-five dollars ($25.00), for each sign, including replacement signs.

(c) The signs required by this section shall:

(1) Be composed of black, capital letters printed on white paper at the minimum weight of one hundred ten pound index. The letters comprising the word 'WARNING' shall be highlighted black lettering and shall be larger than all other lettering on the sign.

(2) Contain the message: 'WARNING Pregnancy and alcohol do not mix. Drinking alcohol during pregnancy can cause birth defects.'

(3) The size of the sign shall be at least eight and one-half inches by 14 inches.

(4) Contain a graphic depiction of the message to assist nonreaders in understanding the message. The depiction of a pregnant female shall be universal and shall not reflect a specific race or culture.

(5) Be in both English and Spanish.

(d) A local ABC board shall ensure that each ABC store manager displays the warning sign in an open and prominent place in the store within 30 days of receipt of the sign from the Commission."

SECTION 3. This act is effective when it becomes law. The Commission and each local ABC board shall be in full compliance with the requirements of this act no later than six months after the day the bill becomes law.

HOUSE BILL 1118:
Display Fetal Alcohol Syndrome Warning Signs.

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Rep. Alexander
Date:	June 4, 2003	**Summary by:**	Sara Kamprath
Version:	2nd Edition		Committee Staff

SUMMARY: ***House Bill 1118 requires each ABC store to prominently display a warning sign stating that drinking alcohol during pregnancy can cause birth defects. The bill further requires the ABC Commission to develop the signs and provide for their distribution. The Commission is also authorized to charge a fee not to exceed $25.00 for each sign, including replacements. The local ABC board is required to ensure that each ABC store manager properly displays the sign within 30 days of its receipt.***

The bill would become effective when it becomes law. The Commission and each local ABC board would have six months from the effective date to be in full compliance with the act.

CURRENT LAW: The operation of ABC stores is governed by Article 8 of Chapter 18B, which addresses the opening and closing of stores, the operating hours, the store management, the pricing of alcohol, and the distribution of revenues. ABC stores are under the authority of and operated by a local ABC board.

BILL ANALYSIS: House Bill 1118 does the following:

- ***Requirement for ABC stores.*** – It requires each ABC store to display a warning sign, developed by the ABC Commission, that warns about the dangers of alcohol and pregnancy. Specifically, the sign would state:

  WARNING: Pregnancy and alcohol do not mix.
  Drinking alcohol during pregnancy can cause birth defects.

- ***Requirement for ABC Commission.*** – It requires the ABC Commission to develop and distribute the warning signs. The Commission may charge a fee not to exceed $25.00 for each sign, including replacements. The bill specifies that the signs must:
  - Be on certain paper and in certain lettering.
  - Be at least 8½ x 14 in size.
  - Be in both English and Spanish.
  - Contain a graphic depiction of the message for nonreaders.

- ***Requirement for local ABC boards.*** – It requires local ABC boards to ensure that each ABC store manager posts the warning sign in an open and prominent place in the store within 30 days of its receipt.

BACKGROUND: Fetal Alcohol Syndrome (FAS) is a set of physical, mental, and neurobehavioral birth defects caused by maternal consumption of alcohol during pregnancy. FAS is considered the most common nonhereditary cause of mental retardation. In addition to deficits in general intellectual functioning, individuals with FAS often demonstrate difficulties with learning, memory, attention, and problem solving as well as problems with mental health and social interactions. Although prenatal alcohol exposure does not always result in FAS, there is no known safe level of alcohol consumption during pregnancy. FAS is 100% preventable when a woman completely abstains from alcohol during her pregnancy.[1]

[1]This information was obtained from the National Organization on Fetal Alcohol Syndrome.

As of February, **nineteen** states have laws that require businesses that sell or serve alcohol to display a warning sign about fetal alcohol syndrome: Alaska, Arizona, California, Delaware, Florida, Georgia, Illinois, Kentucky, Minnesota, Nebraska, New Jersey, New Mexico, New York, Oregon, South Dakota, Tennessee, Utah, Washington, and West Virginia. Cities that have passed such ordinances include: Washington, D.C.; Racine, Wisconsin; Philadelphia, Pennsylvania; Lakewood and Columbus, Ohio; New Orleans, Alexandria/Pineville, and Monroe, Louisiana.

Trina Griffin, Committee Counsel, contributed significantly to this summary.

H1118-SMRJ-001

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: House Bill 1118 (Second Edition)

SHORT TITLE: Display Fetal Alcohol Syndrome Warning

SPONSOR(S): Rep. Alexander

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES					
ABC Fund	up to $10,000				
EXPENDITURES					
Local ABC Board	up to $10,000				
POSITIONS: (cumulative)					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Alcoholic Beverage Control Commission, Local ABC Boards

EFFECTIVE DATE: This act is effective when it becomes law. The Commission and each local ABC board shall be in full compliance with the law no later than six months after the day the bill becomes law.

BILL SUMMARY: The bill requires the posting of signs in Alcoholic Beverage Control (ABC) stores warning of the possible dangers of consumption of alcohol during pregnancy.

ASSUMPTIONS AND METHODOLOGY: The maximum $25 fee from each of the state's 400 ABC stores will generate $10,000. An administrator of the ABC Commission thinks the $25 fee is more than sufficient to cover the costs of the signs. In fact, the Commission may choose to pay for the signs out of its operating budget rather than bother with collecting fees from the local ABC boards.

SOURCES OF DATA: Alcoholic Beverage Control Commission

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Richard Bostic

APPROVED BY: James D. Johnson, Director, Fiscal Research Division

DATE: May 21, 2003

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 3

HOUSE BILL 152

Committee Substitute Favorable 4/9/03
Third Edition Engrossed 4/21/03

Short Title: Unauthorized Meds./Prevent SIDS/Child Care. (Public)

Sponsors:

Referred to:

March 3, 2003

A BILL TO BE ENTITLED

AN ACT REQUIRING CHILD CARE FACILITIES TO PLACE CHILDREN IN A SLEEPING POSITION THAT REDUCES THE RISK OF SUDDEN INFANT DEATH SYNDROME (SIDS), PROHIBITING THE ADMINISTRATION OF MEDICATION TO A CHILD IN A LICENSED OR UNLICENSED CHILD CARE FACILITY WITHOUT PROPER AUTHORIZATION FROM THE CHILD'S PARENT OR GUARDIAN, AND REQUIRING CERTAIN AGENCIES AND THE MEDICAL COMMUNITY TO COOPERATE IN INVESTIGATING REPORTS OF CHILD ABUSE AND NEGLECT IN CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91 is amended by adding a new subdivision to read:

"**§ 110-91. Mandatory standards for a license.**

All child care facilities shall comply with all State laws and federal laws and local ordinances that pertain to child health, safety, and welfare. Except as otherwise provided in this Article, the standards in this section shall be complied with by all child care facilities. However, none of the standards in this section apply to the school-age children of the operator of a child care facility but do apply to the preschool-age children of the operator. Children 13 years of age or older may receive child care on a voluntary basis provided all applicable required standards are met. The standards in this section, along with any other applicable State laws and federal laws or local ordinances, shall be the required standards for the issuance of a license by the Secretary under the policies and procedures of the Commission except that the Commission may, in its discretion, adopt less stringent standards for the licensing of facilities which provide care on a temporary, part-time, drop-in, seasonal, after-school or other than a full-time basis.

...

(15) Proper Placement of Sleeping Child. – A caregiver in a child care facility shall place a child age 12 months or younger on the child's

back for sleeping to reduce the risks associated with Sudden Infant Death Syndrome (SIDS) unless the caregiver receives a written waiver from a health care provider as defined in G.S. 58-50-61, a parent, or a legal guardian instructing otherwise. Operators of child care facilities that care for children ages 12 months or younger shall develop a written safe sleep policy, in accordance with rules adopted by the North Carolina Child Care Commission, and shall discuss the policy with a child's parent or guardian before the child is enrolled in the child care facility. The child's parent or guardian shall sign a statement attesting that he or she received a copy of the safe sleep policy and that the policy was discussed with him or her before the child's enrollment. Any caregiver responsible for the care of children ages 12 months or younger shall receive training in safe sleep practices."

SECTION 2. Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-102.1A. Unauthorized administration of medication; investigations.**

(a) It is unlawful for an employee, owner, household member, substitute, volunteer, or operator of a licensed or unlicensed child care facility to do either of the following:

(1) Administer any type of drug or medication to a child attending the child care facility if the person administering the drug or medication knew or should have known that written authorization was not obtained from the child's parent or guardian in accordance with rules adopted by the North Carolina Child Care Commission.

(2) Direct another to administer any type of drug or medication to a child attending the child care facility if the person directing another to administer the drug or medication knew or should have known that written authorization was not obtained from the child's parent or guardian in accordance with rules adopted by the North Carolina Child Care Commission.

Any person who violates this subsection is guilty of a Class A1 misdemeanor.

(b) The Division of Child Development, local departments of social services, and local law enforcement personnel shall cooperate with the medical community to ensure that reports of child abuse or neglect in child care facilities are properly investigated."

SECTION 3. G.S. 110-103A(a), as enacted by Section 2 of this act, becomes effective December 1, 2003, and applies to offenses committed on or after that date. The remainder of this act becomes effective December 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 152

Committee Substitute Favorable 4/9/03
Third Edition Engrossed 4/21/03
PROPOSED SENATE COMMITTEE SUBSTITUTE H152-PCS60370-SW-40

Short Title: Prevent SIDS/Child Care/Investigations. (Public)

Sponsors:

Referred to:

March 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CHILD CARE FACILITIES TO DEVELOP AND MAINTAIN A SAFE SLEEP POLICY THAT INCLUDES REQUIRING CAREGIVERS TO PLACE CHILDREN ON THEIR BACK TO SLEEP TO REDUCE THE RISK OF SUDDEN INFANT DEATH SYNDROME (SIDS), AND TO REQUIRE CERTAIN AGENCIES AND THE MEDICAL COMMUNITY TO COOPERATE IN INVESTIGATING REPORTS OF CHILD ABUSE AND NEGLECT IN CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91 is amended by adding a new subdivision to read:

"**§ 110-91. Mandatory standards for a license.**

All child care facilities shall comply with all State laws and federal laws and local ordinances that pertain to child health, safety, and welfare. Except as otherwise provided in this Article, the standards in this section shall be complied with by all child care facilities. However, none of the standards in this section apply to the school-age children of the operator of a child care facility but do apply to the preschool-age children of the operator. Children 13 years of age or older may receive child care on a voluntary basis provided all applicable required standards are met. The standards in this section, along with any other applicable State laws and federal laws or local ordinances, shall be the required standards for the issuance of a license by the Secretary under the policies and procedures of the Commission except that the Commission may, in its discretion, adopt less stringent standards for the licensing of facilities which provide care on a temporary, part-time, drop-in, seasonal, after-school or other than a full-time basis.

...

(15) Safe Sleep Policy. – Operators of child care facilities that care for children ages 12 months or younger shall develop and maintain a written safe sleep policy, in accordance with rules adopted by the Commission. The safe sleep policy shall address maintaining a safe sleep environment and shall include the following requirements:

a. A caregiver in a child care facility shall place a child age 12 months or younger on the child's back for sleeping, unless the operator of the child care facility obtains a written waiver of this requirement from a health care provider as defined in G.S. 58-50-61(a)(8).

b. The operator of the child care facility shall discuss the safe sleep policy with the child's parent or guardian before the child is enrolled in the child care facility. The child's parent or guardian shall sign a statement attesting that the parent or guardian received a copy of the safe sleep policy and that the policy was discussed with the parent or guardian before the child's enrollment.

c. Any caregiver responsible for the care of children ages 12 months or younger shall receive training in safe sleep practices."

SECTION 2. G.S. 110-105.2(a) reads as rewritten:

"(a) For purposes of this Article, child abuse and neglect, as defined in G.S. 7B-101 and in G.S. 14-318.2 and G.S. 14-318.4, occurring in child care facilities, are violations of the licensure standards and of the licensure law. The Department, local departments of social services, and local law enforcement personnel shall cooperate with the medical community to ensure that reports of child abuse or neglect in child care facilities are properly investigated."

SECTION 3. This act becomes effective December 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 152

Committee Substitute Favorable 4/9/03

Third Edition Engrossed 4/21/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H152-CSSW-40 [v.6]

6/3/2003 5:06:00 PM

Short Title: Prevent SIDS/Child Care/Investigations. (Public)

Sponsors:

Referred to:

March 3, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CHILD CARE FACILITIES TO DEVELOP AND MAINTAIN A SAFE SLEEP POLICY THAT INCLUDES REQUIRING CAREGIVERS TO PLACE CHILDREN ON THEIR BACK TO SLEEP TO REDUCE THE RISK OF SUDDEN INFANT DEATH SYNDROME (SIDS), AND TO REQUIRE CERTAIN AGENCIES AND THE MEDICAL COMMUNITY TO COOPERATE IN INVESTIGATING REPORTS OF CHILD ABUSE AND NEGLECT IN CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91 is amended by adding a new subdivision to read:

"**§ 110-91. Mandatory standards for a license.**

All child care facilities shall comply with all State laws and federal laws and local ordinances that pertain to child health, safety, and welfare. Except as otherwise provided in this Article, the standards in this section shall be complied with by all child care facilities. However, none of the standards in this section apply to the school-age children of the operator of a child care facility but do apply to the preschool-age children of the operator. Children 13 years of age or older may receive child care on a voluntary basis provided all applicable required standards are met. The standards in this section, along with any other applicable State laws and federal laws or local ordinances, shall be the required standards for the issuance of a license by the Secretary under the policies and procedures of the Commission except that the Commission may, in its discretion, adopt less stringent standards for the licensing of facilities which provide care on a temporary, part-time, drop-in, seasonal, after-school or other than a full-time basis.

...

(15) Safe Sleep Policy. – Operators of child care facilities that care for children ages 12 months or younger shall develop and maintain a written safe sleep policy, in accordance with rules adopted by the Commission. The safe sleep policy shall address maintaining a safe sleep environment and shall include the following requirements:

a. A caregiver in a child care facility shall place a child age 12 months or younger on the child's back for sleeping, unless the operator of the child care facility obtains a written waiver of this requirement from a health care provider as defined in G.S. 58-50-61(a)(8).

b. The operator of the child care facility shall discuss the safe sleep policy with the child's parent or guardian before the child is enrolled in the child care facility. The child's parent or guardian shall sign a statement attesting that the parent or guardian received a copy of the safe sleep policy and that the policy was discussed with the parent or guardian before the child's enrollment.

c. Any caregiver responsible for the care of children ages 12 months or younger shall receive training in safe sleep practices."

SECTION 2. G.S. 110-105.2(a) reads as rewritten:

"(a) For purposes of this Article, child abuse and neglect, as defined in G.S. 7B-101 and in G.S. 14-318.2 and G.S. 14-318.4, occurring in child care facilities, are violations of the licensure standards and of the licensure law. The Department, local departments of social services, and local law enforcement personnel shall cooperate with the medical community to ensure that reports of child abuse or neglect in child care facilities are properly investigated."

SECTION 3. This act becomes effective December 1, 2003.

HOUSE BILL 152:
Prevent SIDS/Child Care/Investigations

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Representative Alexander
		Summary by:	Dianna Jessup Committee Counsel
Date:	June 4, 2003		
Version:	PCS H152-CSSW-40		

SUMMARY: House Bill 152 would require operators of child care facilities that care for children age 12 months or younger to develop and maintain a safe sleep policy, in accordance with rules adopted by the Child Care Commission. The bill would also require cooperation between various agencies and the medical community in investigations of child abuse or neglect in child care facilities.

The PCS reorganizes Section 1 of the bill (safe sleeping), deleted the language permitting parents to "opt out" of the back-to-sleep requirement, deleted the language regarding unauthorized medications, and inserted the language regarding cooperation in investigating abuse and neglect in G.S. 110-105.2.

CURRENT LAW: Article 7 of Chapter 110 of the North Carolina General Statutes establishes the Child Care Commission and sets out requirements for the provision of child care in North Carolina. Child care facilities must meet certain minimum standards to be licensed to operate, and it is unlawful to operate a child care facility without being licensed. As defined in G.S. 110-86, "child care facility" includes child care centers (i.e. three or more preschool-age children or nine or more school-age children receiving care at one time), family child care homes (i.e. more than two but less than nine children receiving care at one time in a residence), and other child care arrangements. However, the following child care arrangements are excluded:

- Arrangements operated in the home of any child receiving care if all of the children in care are related to each other and no more than two other children are in care.
- Recreational programs operated for less than four consecutive months in a year.
- Specialized activities or instruction (such as athletics), or organized clubs for children (such as Girl Scouts).
- Drop-in or short-term care provided while parents participate in non-employment related activities and where the parents are on the premises or otherwise easily accessible.
- Public schools.
- Nonpublic schools described in Part 2 of Article 39 of Chapter 115C that are accredited by the Southern Association of Colleges and Schools and that operate a child care facility for less than six and one-half hours per day either on or off the school site.
- Bible schools conducted during vacation periods.
- Care provided by licensed facilities for the mentally ill, the developmentally disabled, and substance abusers.
- Cooperative arrangements among parents to provide care for their own children as a convenience rather than for employment.
- Any child care program consisting of two or more separate components, each of which operates for four hours or less per day with different children attending each component.

The North Carolina Child Care Commission currently has the statutory authority to adopt rules and standards for child care facilities in the State.

A child care facility that violates any statutory requirement or rule adopted by the Child Care Commission is subject to administrative and civil penalties. The Secretary of the Department of Health and Human Services may impose one or more of the following against a licensee:

- Issue a written warning and a request for compliance.
- Issue an official reprimand.
- Place a licensee on probation until compliance is verified by the Commission.
- Suspend a license for a period not to exceed one year.
- Permanently revoke a license.

A civil penalty may also be levied against a child care facility in an amount not to exceed $1000 for each violation documented on any given date. In determining the amount of the penalty, the threat or extent of harm to children in care, as well as consistency of violations, must be considered.

BILL ANALYSIS: House Bill 152 would amend Article 7 of Chapter 110 to do the following:

Safe sleeping policies:

G.S. 110-91 sets out a list of mandatory standards with which all child care facilities must comply in order to become licensed. Section 1 of the PCS would add to that list a requirement that child care facilities place children age 12 months or younger on their backs for sleeping to reduce the risks associated with SIDS, unless the caregiver receives a written waiver from a health care provider instructing otherwise.

Section 1 would also require child care facilities that care for children age 12 months or younger to develop and maintain a written safe sleep policy in accordance with rules adopted by the North Carolina Child Care Commission, which must contain the following requirements:

- Caregivers must place children age 12 months or younger on their backs for sleeping.
- The policy must be discussed with a child's parent or guardian before the child is enrolled. The child's parent or guardian would be required to sign a statement attesting that he or she received a copy of the policy and that the policy was discussed prior to enrollment.
- Any caregiver responsible for the care of children age 12 months or younger would be required to receive training in safe sleep practices.

Cooperation in investigations of child abuse or neglect in child care facilities:

Section 2 of the bill would also direct the Division of Child Development, local departments of social services, and local law enforcement personnel to cooperate with the medical community to ensure that reports of abuse or neglect in child care facilities are properly investigated.

EFFECTIVE DATE: The bill would become effective December 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 602

Short Title:	Controlled Substance/Physician Registration.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health & Human Resources.	

March 31, 2003

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PHYSICIANS WHO DISPENSE THE CONTROLLED SUBSTANCE BUPRENORPHINE FOR THE TREATMENT OF OPIATE DEPENDENCE TO REGISTER WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-101 reads as rewritten:

"**§ 90-101. Annual registration and fee to engage in listed activities with controlled substances; effect of registration; exceptions; waiver; inspection.**

(a) Every person who manufactures, distributes, dispenses, or conducts research with any controlled substance within this State or who proposes to engage in any of these activities shall annually register with the North Carolina Department of Health and Human Services, in accordance with rules adopted by the Commission, and shall pay the registration fee set by the Commission for the category to which the applicant belongs. An applicant for registration shall file an application for registration with the Department of Health and Human Services and submit the required fee with the application. The categories of applicants and the maximum fee for each category are as follows:

CATEGORY	MAXIMUM FEE
Clinic	$150.00
Hospital	350.00
Nursing Home	150.00
Teaching Institution	150.00
Researcher	150.00
Analytical Laboratory	150.00
Distributor	600.00
Manufacturer	700.00.

(a1) Any physician who dispenses Buprenorphine for the treatment of opiate dependence shall annually register with the Department, in accordance with rules adopted by the Commission, and shall pay an annual registration fee of two hundred fifty dollars ($250.00). In the application for registration under this subsection, the applicant shall document plans to ensure that patients are directly engaged or referred to a qualified provider to receive counseling and case management, as appropriate, and shall acknowledge the application of federal confidentiality regulations to patient information.

(b) Persons registered by the North Carolina Department of Health and Human Services under this Article (including research facilities) to manufacture, distribute, dispense or conduct research with controlled substances may possess, manufacture, distribute, dispense or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this Article.

(c) The following persons shall not be required to register and may lawfully possess controlled substances under the provisions of this Article:

(1) An agent, or an employee thereof, of any registered manufacturer, distributor, or dispenser of any controlled substance if such agent is acting in the usual course of his business or employment;

(2) The State courier service operated by the Department of Administration, a common or contract carrier, or a public warehouseman, or an employee thereof, whose possession of any controlled substance is in the usual course of his business or employment;

(3) An ultimate user or a person in possession of any controlled substance pursuant to a lawful order of a practitioner;

(4) Repealed by Session Laws 1977, c. 891, s. 4.

(5) Any law-enforcement officer acting within the course and scope of official duties, or any person employed in an official capacity by, or acting as an agent of, any law-enforcement agency or other agency charged with enforcing the provisions of this Article when acting within the course and scope of official duties; and

(6) A practitioner, as defined in G.S. 90-87(22)a., who is required to be licensed in North Carolina by his respective licensing board.

(d) The Commission may, by rule, waive the requirement for registration of certain classes of manufacturers, distributors, or dispensers if it finds it consistent with the public health and safety.

(e) A separate registration shall be required at each principal place of business, research or professional practice where the registrant manufactures, distributes, dispenses or uses controlled substances.

(f) The North Carolina Department of Health and Human Services is authorized to inspect the establishment of a registrant, applicant for registration, or practitioner in accordance with rules adopted by the Commission.

(g) Practitioners licensed in North Carolina by their respective licensing boards may possess, dispense or administer controlled substances to the extent authorized by law and by their boards.

(h) A physician licensed by the North Carolina Medical Board pursuant to Article 1 of this Chapter may possess, dispense or administer tetrahydrocannabinols in duly constituted pharmaceutical form for human administration for treatment purposes pursuant to rules adopted by the Commission.

(i) A physician licensed by the North Carolina Medical Board pursuant to Article 1 of this Chapter may dispense or administer Dronabinol or Nabilone as scheduled in G.S. 90-90(5) only as an antiemetic agent in cancer chemotherapy."

SECTION 2. This act becomes effective October 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 852

Short Title:	Expand Advance Health Care Registry.	(Public)
Sponsors:	Senator Metcalf.	
Referred to:	Health & Human Resources.	

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE ADVANCE HEALTH CARE DIRECTIVES REGISTRY TO INCLUDE A SEPARATE REGISTRY FOR REGISTRATION OF CONSENT FOR ORGAN, TISSUE, OR EYE DONATION; TO ESTABLISH THE LIFE DECISIONS REGISTRY TRUST FUND; TO PROVIDE FOR VOLUNTARY DONATIONS TO THE LIFE DECISIONS REGISTRY TRUST FUND THROUGH INCOME TAX REFUND CONTRIBUTIONS AND THROUGH CONTRIBUTIONS MADE AT THE TIME OF APPLICATION FOR DRIVERS LICENSE AND MOTOR VEHICLE REGISTRATION.

The General Assembly of North Carolina enacts:

SECTION 1. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 852
PROPOSED COMMITTEE SUBSTITUTE S852-PCS40043-LN-11

Short Title: Organ Donor Org's./Access to DMV Records. (Public)

Sponsors:

Referred to:

April 3, 2003

A BILL TO BE ENTITLED

AN ACT TO PROVIDE INTERNET ACCESS BY ORGAN PROCUREMENT ORGANIZATIONS AND EYE BANKS TO INFORMATION IN DIVISION OF MOTOR VEHICLE RECORDS PERTAINING TO ORGAN DONATION; TO ESTABLISH THE "LICENSE TO GIVE TRUST FUND" TO FUND INITIATIVES THAT EDUCATE AND PROMOTE ORGAN AND TISSUE DONATION; TO AUTHORIZE INDIVIDUAL CONTRIBUTIONS OF ONE DOLLAR TO THE "LICENSE TO GIVE TRUST FUND" TO BE COLLECTED AT THE TIME OF DRIVERS LICENSE OR SPECIAL IDENTIFICATION CARD APPLICATION AT MOTOR VEHICLE OFFICES; AND TO APPROPRIATE FUNDS TO IMPLEMENT THIS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Transportation, Division of Motor Vehicles, shall establish and maintain a statewide, on-line Organ Donor Internet site. The purpose of the Organ Donor Internet site is to enable organ procurement organizations and eye banks to have timely access to the names of individuals who have stated to the Division the individual's intent to be an organ donor and have an organ donation symbol on the individual's drivers license or special identification card. The data available on the Organ Donor Internet site shall be limited to the individual's first, middle, and last name, date of birth, address, sex, county of residence, and drivers license number. The Division of Motor Vehicles shall ensure that only organ procurement organizations and eye banks operating in this State have access to the Organ Donor Internet site in read-only format. The Division of Motor Vehicles shall enable organ procurement organizations and eye banks operating in this State to have on-line access in read-only format to the Organ Donor Internet site through a unique identifier and password issued to the organ procurement organization or eye bank by the Division of Motor Vehicles. Employees of the Division who provide access to or disclosure of information in good-faith compliance with this section are not liable in

damages for access to or disclosure of the information. When accessing and using information obtained from the Organ Donor Internet site, organ procurement organizations and eye banks shall comply with the requirements of Part 3 of Article 16 of Chapter 130A of the General Statutes.

SECTION 2. G.S. 20-43.1 reads as rewritten:

"**§ 20-43.1. Disclosure of personal information in motor vehicle records.**

(a) The Division shall disclose personal information contained in motor vehicle records in accordance with the federal Driver's Privacy Protection Act of 1994, as amended, 18 U.S.C. §§ 2721, et seq.

(b) As authorized in 18 U.S.C. § 2721, the Division shall not disclose personal information for the purposes specified in 18 U.S.C. § 2721(b)(11).

(c) The Division shall not disclose personal information for the purposes specified in 18 U.S.C. § 2721(b)(12) unless the Division receives prior written permission from the person about whom the information is requested.

(d) As authorized in 18 U.S.C. § 2721, the Division may disclose personal information to organ procurement organizations and eye banks operating in this State for the purpose of identifying individuals who have indicated an intent to be an organ donor. Personal information authorized under this subsection is limited to the individual's first, middle, and last name, date of birth, address, sex, county of residence, and drivers license number. Employees of the Division who provide access to or disclosure of information in good-faith compliance with this subsection are not liable in damages for access to or disclosure of the information."

SECTION 3. G.S. 20-7.3 reads as rewritten:

"**§ 20-7.3. Availability of organ, eye, and tissue donor cards at motor vehicle ~~offices.~~offices; contributions to License to Give Trust Fund.**

(a) The Division shall make organ, eye, and tissue donor cards available to interested individuals in each office authorized to issue drivers licenses or special identification cards. The Division shall obtain donor cards from qualified organ, eye, or tissue procurement organizations or tissue banks, as defined in G.S. 130A-403. The Division shall offer a donor card to each applicant for a drivers license. Each organ donor card made available at drivers license offices shall include the following:

(1) A statement informing the individual that organ procurement organizations and eye banks have read-only access to the Department-operated Organ Donor Internet site listing those individuals who have stated to the Division of Motor Vehicles the individual's intent to be an organ donor and have an organ donation symbol on the individual's drivers license or special identification card.

(2) The type of information that will be made available on the Organ Donor Internet site.

(b) An applicant for a drivers license or special identification card may elect to contribute one dollar ($1.00) to the License to Give Trust Fund established under G.S. 20-7.4. The Division shall provide appropriate language on the drivers license or special identification card application form or other form in which to make the election. The contribution made under this subsection is in addition to applicable drivers license and

identification card fees. The election becomes irrevocable upon payment of the contribution with license or identification card fees. The Division shall quarterly transmit the contributions made pursuant to this subsection to the State Treasurer for credit to the License to Give Trust Fund. Any interest earned on funds so credited is credit to the Fund."

SECTION 4.(a) Article 2 of Chapter 20 of the General Statutes is amended by adding the following new section to read:

"**§ 20-7.4. License to Give Trust Fund established.**

(a) There is established the License to Give Trust Fund. Revenue in the Fund includes amounts credited under G.S. 20-7.3, and other funds. Any surplus in the Fund shall not revert but shall be used for the purposes stated in this section. The Fund shall be kept on deposit with the State Treasurer, as in the case of other State Funds, and may be invested by the State Treasurer in any lawful securities for investment of State funds. The License to Give Trust Fund is subject to oversight by the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes. On July 1 of each fiscal year the State Treasurer shall transfer from the Trust Fund to the Department of Transportation an amount sufficient to pay the actual costs incurred by the Department of Transportation to establish and maintain the Organ Donor Internet site.

(b) After funds have been transferred by the State Treasurer to the Department of Transportation pursuant to subsection (a) of this section, purposes for which funds may be expended by the License to Give Trust Fund Commission from the License to Give Trust Fund are as follows:

(1) As grants-in-aid for initiatives that educate about and promote organ and tissue donation and health care decision making at life's end.

(2) Expenses of the License to Give Trust Fund Commission as authorized in G.S. 20-7.5."

SECTION 4.(b) Article 2 of Chapter 20 of the General Statutes is amended by adding the following new sections to read:

"**§ 20-7.5. License to Give Trust Fund Commission established.**

(a) There is established the License to Give Trust Fund Commission. The Commission shall be located in the Department of Administration for budgetary and administrative purposes only. The Commission may allocate funds from the License to Give Trust Fund for the purposes authorized in G.S. 20-7.4. The Commission shall have 15 members, appointed as follows:

(1) Four members by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate:

a. One representative of Carolina Donor Services.

b. One representative of LifeShare of The Carolinas.

c. Two members who have demonstrated an interest in organ and tissue donation and education.

(2) Four members by the General Assembly, upon the recommendation of the Speaker of the House of Representatives:

a. One representative of The North Carolina Eye Bank, Inc.

b. One representative of The Carolinas Center for Hospice and End-of-Life Care.

c. Two members who have demonstrated an interest in promoting advance care planning education.

(3) Seven members by the Governor:

a. Three members representing organ, tissue, and eye recipients, families of recipients, or families of donors. Of these three, one each from the mountain, heartland, and coastal regions of the State.

b. One member who is a transplant physician licensed to practice medicine in this State.

c. One member who has demonstrated an interest in organ and tissue donation and education.

d. One member who has demonstrated an interest in promoting advance care planning education.

e. A representative of the North Carolina Department of Transportation.

(b) The Commission shall elect from its membership a chair and a vice-chair for two-year terms. The Secretary of Administration shall provide meeting facilities for the Commission as required by the Chair.

(c) The members of the Commission shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 138-5 and G.S. 138-6, as applicable. Per diem, subsistence, and travel expenses of the members shall be paid from the License to Give Trust Fund.

(d) The members of the Commission shall comply with G.S. 14-234 prohibiting conflicts of interest. In addition to the restrictions imposed under G.S. 14-234, a member shall not vote on, participate in the deliberations of, or otherwise attempt through his or her official capacity to influence the vote on allocations of moneys from the License to Give Trust Fund to a nonprofit entity of which the member is an officer, director, or employee, or to a governmental entity of which the member is an employee or a member of the governing board. A violation of this subsection is a Class 1 misdemeanor.

"**§ 20-7.6. Powers and duties of the License to Give Trust Fund Commission.**

The License to Give Trust Fund Commission has the following powers and duties:

(1) Establish general policies and guidelines for awarding grants-in-aid to nonprofit entities to conduct education and awareness activities on organ and tissue donation and advance care planning.

(2) Accept gifts or grants from other sources to further the purposes of the License to Give Trust Fund. Such gifts or grants shall be transmitted to the State Treasurer for credit to the Fund.

(3) Hire staff or contract for other expertise for the administration of the Fund. Expenses related to staffing shall be paid from the License to Give Trust Fund."

SECTION 5. There is appropriated from the General Fund to the Department of Transportation, Division of Motor Vehicles, the sum of one hundred thousand dollars ($100,000) for the 2003-2004 fiscal year and the sum of ten thousand dollars ($10,000) for the 2004-2005 fiscal year. These funds shall be used for start-up and first year maintenance costs of the Organ Donor Internet site in accordance with Section 1 of this act.

SECTION 6. This act becomes effective January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 672

Short Title:	Strengthen Public Health Infrastructure.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Health & Human Resources.	

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT OF STATE AND LOCAL COMPREHENSIVE PUBLIC HEALTH PLANS, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE BY ENHANCING COLLABORATION WITH PUBLIC AND PRIVATE SECTOR ENTITIES AND IMPOSING PERFORMANCE STANDARDS FOR PUBLIC HEALTH PRACTICE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure;

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions;

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies, the collaboration of the public and private sectors within the public health system, and the consolidation of local public health agencies;

Whereas, a consensus for establishing, prioritizing and implementing essential public health services and functions can be achieved through locally developed and coordinated health plans that provide the foundation for a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 is repealed.

SECTION 2. G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-1.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6aa) "Local public health agency" means a local health director, a local board of health, and a local health department.

(6a) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency and are identified in the local public health plans in accordance with G.S. 130A-2.7.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, tribal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(8b) "Tribe" means the same as the term 'Indian Tribe' in 25 U.S.C. § 450b(e), section 4(e) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

(8c) "Tribal public health agency" means any program or organization operated by a tribe or tribal organization, including boards, agencies, commissions, or offices, that principally acts or is responsible to protect or preserve the public's health and shall include the health programs of any tribal organization that carries out essential public health services and functions or otherwise acts to protect or preserve the public health.

(8d) "Tribal organization" means the same as the term in 25 U.S.C. § 450b(l), section 4(l) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 3. Part 1 of Article 1 of Chapter 130A is amended by adding the following new sections to read:

"**§ 130A-2.1. Mission statement.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The mission of the State and local public health agencies is to provide leadership and protect and promote the public's health by:

(1) Providing essential public health services and functions as provided in G.S. 130A-1.3.

(2) Encouraging collaboration among public and private sector partners in the public health system.

(3) Seeking adequate funding to provide essential public health services and functions and to accomplish public health goals from public or private sources.

(c) Nothing in this section shall be construed to require the State or local public health agencies or an individual or agency within the public health system to provide specific health services or to implement unfunded programs.

"**§ 130A-2.2. Responsibilities of State and local governments; private sector collaboration.**

(a) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(b) State and local public health agencies shall collaborate with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-33-55.

(d) State or local public health agencies may contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through these private sector entities if:

(1) The contractor has the potential to improve public health outcomes without causing harm to individuals or the public health system.

(2) Privatized services are fully and regularly monitored by the contracting public health agency or others within the public health system. Nothing is this subdivision shall be construed to require private sector entities to be monitored by other public agencies providing services within the public health system. The State public health agency shall devise, in consultation with others within the public health system, evaluation criteria to be used in conducting performance reviews of any private sector partner that provides privatized services or functions.

(3) Privatized services or functions are subject to other federal, State, or local laws.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies, in collaboration with public and private sector partners, shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Diagnose and investigate health problems and health hazards in the community.

(3) Inform people about health issues.

(4) Develop policies and plans that support individual and community health efforts.

(5) Enforce laws and regulations that protect health and ensure safety.

(6) Link individuals to needed personal health services and facilitate the provision of health care when not otherwise available.

(7) Monitor and ensure the competency of the public health workforce.

(8) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(9) Conduct research to identify new insights and innovative solutions to health problems.

(10) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(11) When not otherwise available through the private sector, collaborate with other public sector partners to promote the availability of and access to preventive and primary health care, including acute and episodic care, prenatal and postpartum care, child health, family

planning, school health, chronic disease preventions, child and adult immunization, dental health, nutrition, and health education and promotion services.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, or the Department of Environment and Natural Resources as otherwise conferred by State law.

"**§ 130A-2.4. Public health infrastructure.**

(a) The Secretary shall coordinate State and local public health agencies and their public and private sector partners to do the following to strengthen and maintain stability of the public health infrastructure:

(1) Identify and provide leadership for the provision of essential public health services and functions;

(2) Develop management standards for the public health system and workforce that are tied to improvements in public health outcomes or other measures;

(3) Develop and provide effective training for members of the public health workforce that is focused on performance-based standards;

(4) Evaluate performance management standards and training efforts within the public health system; and

(5) Comprehensively plan and set priorities for the efficient and effective accomplishment of essential public health services and functions.

(b) In performing the duties set forth in subsection (a) of this section, State and local public health agencies and their public and private sector partners shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

"**§ 130A-2.5. Public health workforce.**

(a) The State public health agency shall manage the public health workforce performance related to public health infrastructure and capacity, processes, and outcomes at the State and local levels. The State public health agency shall establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These include the following:

(1) Performance measurement standards for the public health system. – Consistent with the National Public Health Performance Standards Program, the State public health agency shall adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(2) Accreditation of local public health agencies. – The State public health agency shall adopt and administer a mandatory accreditation program for local public health agencies. The accreditation program shall be based on criteria developed by the State public health agency that

focus on the ability of agencies to provide essential public health services and functions.

(3) Certification or credentialing for the public health workforce. – Consistent with any national system of public health workforce certification or credentialing, the State public health agency shall adopt and administer public health workforce certification or credentialing programs for members of the public health workforce. These programs shall be designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas and must be based on:

a. Basic, core, or technical competencies for public health workers; or

b. Professional codes for public health professionals.

(b) The State public health agency shall, directly or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

(c) The State public health agency may require individuals within the public health system to meet minimal training requirements to assist the individual in providing essential public health services and functions.

(d) The State public health agency may provide incentives to meet performance management or training requirements, including:

(1) Organizational accountability awards.

(2) Accreditation recognition for public health agencies or their contractors or volunteers.

(3) Certification or credentialing titles or recognition for individuals.

(4) Other career development initiatives, including financial benefits.

(e) The State public health agency shall:

(1) Adopt a framework for the evaluation of the performance of the local public health agency workforce.

(2) Develop standards to consistently evaluate the effectiveness and delivery of training programs, continuation education, and other tools.

(3) Consistently evaluate performance management and training programs, continuing education, and other tools pursuant to these frameworks or standards.

"**§ 130A-2.6. Comprehensive public health plan.**

(a) The State public health agency shall develop a comprehensive public health plan ("Plan") that assesses and sets priorities for the State public health system. The State public health agency shall develop the Plan in consultation with representatives from its public and private sector partners and in consideration of local public health plans submitted in accordance with G.S. 130A-2.7. The Plan may rely on existing or available surveillance data or other formation available to the State public health agency, as well as national guidelines or recommendations concerning public health outcomes and improvements. The Plan shall cover five years and shall be reviewed

annually. Future Plans shall be developed every five years. The Plan shall include the following:

(1) Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

(2) Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

(3) Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

(4) Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

(5) Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies and schedules for meeting these goals.

(6) Strategies for coordinating service delivery within the public health system.

(7) Measurable indicators of effectiveness and success.

(8) Identification of public and private sector partners.

(b) The State public health agency shall submit a copy of the comprehensive State public health plan required under this section annually to the Governor and the General Assembly upon its convening or reconvening, including any recommendations for legislative amendments.

"**§ 130A-2.7. Local public health plans.**

(a) Every county, through its local public health agency, shall provide for the development, review, and approval of a local public health plan consistent with the comprehensive State public health plan required under G.S. 130A-5.4. The local public health plan shall address how the local public health agency will coordinate with the State public health agency and others within the public health system to accomplish goal and priorities identified in the comprehensive State public health plan. The local public health plan shall cover five years and shall be reviewed annually. Future plans shall be developed every five years. In addition to the items listed in G.S. 130A-5.4, the local public health plan shall include the following:

(1) Description of the demographics and health indicators of the population being served by the local public health agency.

(2) Description of the numbers and types of professionals in the local public health workforce.

(3) Description of the local public health workforce training needs.

(4) Description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) Description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and are of the highest quality possible.

(6) Description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) Other matters determined by the Secretary to be necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

(b) The local public health plan shall be approved and submitted to the Secretary no later than July 1, 2004.

(c) The State public health agency shall provide technical assistance to local public health agencies that request assistance and shall otherwise work with local public health agencies to generate the plan."

SECTION 4. G.S. 130A-5 reads as rewritten:

"**§ 130A-5. Duties of the Secretary.**

The Secretary shall have the authority:

(1) To enforce the State health laws and the rules of the Commission;

(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish;

(3) To develop and carry out ~~reasonable health programs that may be necessary for the protection and promotion of the public health and the control of diseases.~~ the comprehensive State public health plan pursuant to G.S. 130A-33-58. The Commission is authorized to adopt rules to carry out ~~these programs.~~ the Plan.

(4) To make sanitary and health investigations and inspections;

(5) To investigate occupational health hazards and occupational diseases and to make recommendations for the elimination of the hazards and diseases. The Secretary shall work with the Industrial Commission and shall file sufficient reports with the Industrial Commission to enable it to carry out all of the provisions of the Workers' Compensation Act with respect to occupational disease.

(6) To receive donations of money, securities, equipment, supplies, realty or any other property of any kind or description which shall be used by the Department for the purpose of carrying out its public health programs;

(7) To acquire by purchase, devise or otherwise in the name of the Department equipment, supplies and other property, real or personal, necessary to carry out the public health programs;

(8) To use the official seal of the Department. Copies of documents in the possession of the Department may be authenticated with the seal of the Department, attested by the signature or a facsimile of the signature of the Secretary, and when authenticated shall have the same evidentiary value as the originals;

(9) To disseminate information to the general public on all matters pertaining to public health; to purchase, print, publish, and distribute free, or at cost, documents, reports, bulletins and health informational materials. Money collected from the distribution of these materials shall remain in the Department to be used to replace the materials;

(10) To be the health advisor of the State and to advise State officials in regard to the location, sanitary construction and health management of all State institutions; to direct the attention of the State to health matters which affect the industries, property, health and lives of the people of the State; to inspect at least annually State institutions and facilities; to make a report as to the health conditions of these institutions or facilities with suggestions and recommendations to the appropriate State agencies. It shall be the duty of the persons in immediate charge of these institutions or facilities to furnish all assistance necessary for a thorough inspection;

(11) To establish a schedule of fees based on income to be paid by a recipient for services provided by Migrant Health Clinics and Development Evaluation Centers;

(12) To establish fees for the sale of specimen containers, vaccines and other biologicals. The fees shall not exceed the actual cost of such items, plus transportation costs;

(13) To establish a fee to cover costs of responding to requests by employers for industrial hygiene consultation services and occupational consultation services. The fee shall not exceed two hundred dollars ($200.00) per on site inspection; ~~and~~

(14) To establish a fee for companion animal certificate of examination forms to be distributed, upon request, by the Department to licensed veterinarians. The fee shall not exceed the cost of the form and shipping ~~costs.~~costs;

(15) Conduct performance management and training programs and evaluations to improve the public health system and workforce; and

(16) Systematically review, on at least an annual basis, the public health system to recommend modifications in its structure or other features to improve public health outcomes."

SECTION 5. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the comprehensive State public health plan and the local public health plans:

(1) Develop the State comprehensive public health plan in accordance with G.S. 130A-5.2 not later than January 1, 2005.

(2) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary and identify rules that are inconsistent with this act.

(3) Review all oversight and monitoring functions currently implemented by the Department with respect to the public health system to determine the effectiveness of the activities on achieving the intent of the act; and improve the oversight and monitoring functions and activities, if necessary; identify areas where additional training is needed and provide it.

(4) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(5) Develop format and required content for local public health plans.

(6) Develop a method for Departmental evaluation of local public health plans.

(7) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health plans.

(8) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement public health infrastructure reform no later than October 1, 2003.

(9) Develop a consolidation plan that will result in no less than 10 and no more than 20 local public health agencies by January 1, 2005.

SECTION 6. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one million dollars ($1,000,000) for the 2003-2004 fiscal year. These funds shall be used to create incentives for counties to consolidate public health services into multicounty district health departments.

SECTION 7. Section 6 of this act becomes effective July 1, 2003. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 672
PROPOSED COMMITTEE SUBSTITUTE S672-PCS35309-SP-8

Short Title: Strengthen Public Health Infrastructure. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT OF STATE AND LOCAL COMPREHENSIVE PUBLIC HEALTH PLANS, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE BY ENHANCING COLLABORATION WITH PUBLIC AND PRIVATE SECTOR ENTITIES AND IMPOSING PERFORMANCE STANDARDS FOR PUBLIC HEALTH PRACTICE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure; and

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions; and

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies and the collaboration of the public and private sectors within the public health system; and

Whereas, a consensus for establishing, prioritizing, and implementing essential public health services and functions can be achieved through locally developed and coordinated health plans that provide the foundation for a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 is repealed.

SECTION 2. G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-2.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6a) "Local public health agency" means a local health director, a local board of health, and a local health department.

~~(6a)~~(6b) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency and are

identified in the local public health plans in accordance with G.S. 130A-2.7.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that

the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 3. Part 1 of Article 1 of Chapter 130A of the General Statutes is amended by adding the following new sections to read:

"**§ 130A-2.1. Mission statement.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The mission of the State and local public health agencies is to provide leadership and protect and promote the public's health by:

(1) Providing essential public health services and functions as provided in G.S. 130A-2.3.

(2) Encouraging collaboration among public and private sector partners in the public health system.

(3) Seeking adequate funding to provide essential public health services and functions and to accomplish public health goals from public or private sources.

"**§ 130A-2.2. Responsibilities of State and local governments; private sector collaboration.**

(a) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(b) State and local public health agencies shall collaborate with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-2.3.

(c) State and local public health agencies shall obtain accreditation. Local public health agencies shall meet the accreditation criteria of the accreditation program administered by the State public health agency. The State public health agency shall obtain an accreditation directed at the duties and functions of a state-level public health agency from a national accrediting body.

(d) State or local public health agencies may contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through these private sector entities if:

(1) The contractor has the potential to improve public health outcomes without causing harm to individuals or the public health system.

(2) Contracted services are fully and regularly monitored by the contracting public health agency. The State and local public health agencies shall devise, in consultation with others within the public

health system, evaluation criteria to be used in conducting performance reviews of any private sector partner that provides contracted services or functions.

(3) Contracted services or functions are subject to other federal, State, or local laws.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies, in collaboration with public and private sector partners, shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Mobilize public and private sector collaboration and action to identify and solve health problems.

(3) Diagnose and investigate health problems and health hazards in the community.

(4) Inform people about health issues.

(5) Develop policies and plans that support individual and community health efforts.

(6) Enforce laws and regulations that protect health and ensure a safe and healthful environment.

(7) Promote access to and availability of needed personal health care services and collaborate with other public and private sector partners to promote or provide preventative and primary health care services according to identified community needs. For the purposes of this subdivision, preventative and primary health care services include acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, dental health, nutrition, and health education and promotion services.

(8) Monitor and ensure the competency of the public health workforce.

(9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(10) Conduct research to identify new insights and innovative solutions to health problems.

(11) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(12) Establish and maintain an effective public health preparedness and response capacity for all hazards.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, rules adopted by local boards of health, or the Department of Environment and Natural Resources as otherwise conferred by State law.

"**§ 130A-2.4. Public health infrastructure.**

(a) The Secretary shall coordinate State and local public health agencies and their public and private sector partners to do the following to strengthen and maintain stability of the public health infrastructure:

(1) Identify and provide leadership for the provision of essential public health services and functions;

(2) Develop management standards for the State and local public health workforce that are tied to improvements in public health outcomes or other measures;

(3) Develop and provide effective training for members of the State and local public health workforce that is focused on performance-based standards;

(4) Evaluate performance management standards and training efforts within State and local public health agencies; and

(5) Comprehensively plan and set priorities for the efficient and effective accomplishment of essential public health services and functions.

(b) In performing the duties set forth in subsection (a) of this section, State and local public health agencies shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

"**§ 130A-2.5. Public health workforce.**

(a) The State public health agency shall manage the State and local public health workforce performance related to public health infrastructure and capacity, processes, and outcomes at the State and local levels. The State public health agency shall establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These include the following:

(1) Performance measurement standards for the public health system. – Consistent with the National Public Health Performance Standards Program, the State public health agency shall adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(2) Certification or credentialing for the public health workforce. – Consistent with any approved and recognized system of public health workforce certification or credentialing, the State public health agency shall adopt and administer public health workforce certification or credentialing programs for members of the public health agencies. These programs shall be designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas and must be based on:

a. Basic, core, or technical competencies for public health workers; or

b. Professional codes for public health professionals.

(b) The State public health agency shall, directly or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

(c) The State public health agency may require individuals within the public health system to meet minimal training requirements to assist the individual in providing essential public health services and functions.

(d) The State public health agency may provide incentives to meet performance management or training requirements, including:

(1) Organizational accountability awards.

(2) Accreditation recognition for public health agencies or their contractors or volunteers.

(3) Certification or credentialing titles or recognition for individuals.

(4) Other career development initiatives, including financial benefits.

(e) The State public health agency shall:

(1) Adopt a framework for the evaluation of the performance of the local public health agency workforce.

(2) Develop standards to consistently evaluate the effectiveness and delivery of training programs, continuing education, and other tools.

(3) Consistently evaluate performance management and training programs, continuing education, and other tools pursuant to these frameworks or standards.

"**§ 130A-2.6. Local public health plans.**

(a) Every county, through its local public health agency, shall provide for the development, review, and approval of a local public health plan consistent with the comprehensive State public health plan required under G.S. 130A-2.7. The local public health plan shall address how the local public health agency will coordinate with the State public health agency and others within the public health system to accomplish goals and priorities identified in the comprehensive State public health plan. The local public health plan shall cover five years and shall be reviewed annually. Future plans shall be developed every five years. Prior to the approval of the local public health plan, the local board of health and the board of county commissioners shall hold a public hearing with notice published at least 10 days before the hearing. In addition to the items listed in G.S. 130A-2.7, the local public health plan shall include the following:

(1) A description of the demographics and health indicators of the population being served by the local public health agency.

(2) A description of the numbers and types of professionals in the local public health workforce.

(3) A description of the local public health workforce training needs.

(4) A description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) A description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and of the highest quality possible.

(6) A description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) Other matters determined by the Secretary to be necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

(b) The State public health agency shall provide technical assistance to local public health agencies that request assistance and shall otherwise work with local public health agencies to generate the plan.

"**§ 130A-2.7. Comprehensive State public health plan.**

(a) The State public health agency shall develop a comprehensive public health plan ("Plan") that assesses and sets priorities for the State public health system based on local public health plans developed and submitted in accordance with G.S. 130A-2.6. The State public health agency shall develop the Plan in consultation with representatives from its public and private sector partners. The Plan may rely on existing or available surveillance data or other information available to the State public health agency, as well as national guidelines or recommendations concerning public health outcomes and improvements. The Plan shall cover five years and shall be reviewed annually. Future Plans shall be developed every five years. Prior to the adoption of the Plan, the State public health agency shall hold public hearings around the State with notice published at least 10 days before each hearing. The Plan shall include the following:

(1) Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

(2) Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

(3) Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

(4) Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

(5) Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies, and schedules for meeting these goals.

(6) Strategies for coordinating service delivery within the public health system.

(7) Measurable indicators of effectiveness and success.

(8) Identification of public and private sector partners.

(b) The State public health agency shall submit a copy of the comprehensive State public health plan required under this section annually to the Governor and the General Assembly upon its convening or reconvening, including any recommendations for legislative amendments."

SECTION 4. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the comprehensive State public health plan and the local public health plans:

(1) Ensure that local public health plans required under G.S. 130A-2.6 are completed and submitted no later than July 1, 2004.

(2) Develop the State comprehensive public health plan in accordance with G.S. 130A-2.7 not later than January 1, 2005.

(3) In consultation with local public health agencies, the State public health agency shall develop and administer an accreditation program not later than January 1, 2005. The program shall include criteria that measure the local public health agencies' capacity to provide, in collaboration with public and private sector partners, all essential public health services and functions listed in G.S. 130A-2.3 in a manner that promotes quality and financial sustainability.

(4) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary of Health and Human Services and identify rules that are inconsistent with this act.

(5) Review all oversight and monitoring functions currently implemented by the Department with respect to the public health system to determine the effectiveness of the activities on achieving the intent of this act; improve the oversight and monitoring functions and activities, if necessary; and identify areas where additional training is needed and provide it.

(6) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(7) Develop format and required content for local public health plans.

(8) Develop a method for Departmental evaluation of local public health plans.

(9) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health plans.

(10) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement public health infrastructure reform no later than October 1, 2004.

(11) In consultation with officials from the North Carolina Boards of Health, the North Carolina Association of Local Health Directors, and the North Carolina Association of County Commissioners, develop and implement a consolidation plan based on the accreditation criteria developed pursuant to G.S. 130A-2.5. The consolidation plan shall be

developed no later than January 1, 2005, and shall be fully implemented no later than July 1, 2006.

SECTION 5. There is appropriated from the General Fund to the Department of Health and Human Services the sum of twenty-five thousand dollars ($25,000) for the 2003-2004 fiscal year. These funds shall be used by the Department of Health and Human Services to conduct the public hearings required by this act.

SECTION 6. Section 5 of this act becomes effective July 1, 2003. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 672
PROPOSED COMMITTEE SUBSTITUTE S672-CSSP-8 [v.5]

6/3/2003 4:18:13 PM

Short Title: Strengthen Public Health Infrastructure. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT OF STATE AND LOCAL COMPREHENSIVE PUBLIC HEALTH PLANS, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE BY ENHANCING COLLABORATION WITH PUBLIC AND PRIVATE SECTOR ENTITIES AND IMPOSING PERFORMANCE STANDARDS FOR PUBLIC HEALTH PRACTICE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure;

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions;

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies, and the collaboration of the public and private sectors within the public health system; and

Whereas, a consensus for establishing, prioritizing and implementing essential public health services and functions can be achieved through locally developed and coordinated health plans that provide the foundation for a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 is repealed.

SECTION 2. G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-2.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6aa) "Local public health agency" means a local health director, a local board of health, and a local health department.

(6a) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency and are

identified in the local public health plans in accordance with G.S. 130A-2.7.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that

the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 3. Part 1 of Article 1 of Chapter 130A is amended by adding the following new sections to read:

"**§ 130A-2.1. Mission statement.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The mission of the State and local public health agencies is to provide leadership and protect and promote the public's health by:

(1) Providing essential public health services and functions as provided in G.S. 130A-2.3.

(2) Encouraging collaboration among public and private sector partners in the public health system.

(3) Seeking adequate funding to provide essential public health services and functions and to accomplish public health goals from public or private sources.

"**§ 130A-2.2. Responsibilities of State and local governments; private sector collaboration.**

(a) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(b) State and local public health agencies shall collaborate with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-2.3.

(c) State and local public health agencies shall obtain accreditation. Local public health agencies shall meet the accreditation criteria of the accreditation program administered by the State public health agency. The State public health agency shall obtain an accreditation directed at the duties and functions of a state level public health agency from a national accrediting body.

(d) State or local public health agencies may contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through these private sector entities if:

(1) The contractor has the potential to improve public health outcomes without causing harm to individuals or the public health system.

(2) Contracted services are fully and regularly monitored by the contracting public health agency. The State and local public health agencies shall devise, in consultation with others within the public

health system, evaluation criteria to be used in conducting performance reviews of any private sector partner that provides contracted services or functions.

(3) Contracted services or functions are subject to other federal, State, or local laws.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies, in collaboration with public and private sector partners, shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Mobilize public and private sector collaboration and action to identify and solve health problems.

(3) Diagnose and investigate health problems and health hazards in the community.

(4) Inform people about health issues.

(5) Develop policies and plans that support individual and community health efforts.

(6) Enforce laws and regulations that protect health and ensure a safe and healthful environment.

(7) Promote access to and availability of needed personal health care services and collaborate with other public and private sector partners to promote or provide preventative and primary health care services according to identified community needs. For the purposes of this subdivision preventative and primary health care services include acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, dental health, nutrition, and health education and promotion services.

(8) Monitor and ensure the competency of the public health workforce.

(9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(10) Conduct research to identify new insights and innovative solutions to health problems.

(11) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(12) Establish and maintain an effective public health preparedness and response capacity for all hazards.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, rules adopted by local boards of health, or the Department of Environment and Natural Resources as otherwise conferred by State law.

"**§ 130A-2.4. Public health infrastructure.**

(a) The Secretary shall coordinate State and local public health agencies and their public and private sector partners to do the following to strengthen and maintain stability of the public health infrastructure:

(1) Identify and provide leadership for the provision of essential public health services and functions;

(2) Develop management standards for the State and local public health workforce that are tied to improvements in public health outcomes or other measures;

(3) Develop and provide effective training for members of the State and local public health workforce that is focused on performance-based standards;

(4) Evaluate performance management standards and training efforts within the state and local public health agencies; and

(5) Comprehensively plan and set priorities for the efficient and effective accomplishment of essential public health services and functions.

(b) In performing the duties set forth in subsection (a) of this section, State and local public health agencies shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

"**§ 130A-2.5. Public health workforce.**

(a) The State public health agency shall manage the State and local public health workforce performance related to public health infrastructure and capacity, processes, and outcomes at the State and local levels. The State public health agency shall establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These include the following:

(1) Performance measurement standards for the public health system. – Consistent with the National Public Health Performance Standards Program, the State public health agency shall adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(2) Certification or credentialing for the public health workforce. – Consistent with any approved and recognized system of public health workforce certification or credentialing, the State public health agency shall adopt and administer public health workforce certification or credentialing programs for members of the public health agencies. These programs shall be designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas and must be based on:

a. Basic, core, or technical competencies for public health workers; or

b. Professional codes for public health professionals.

(b) The State public health agency shall, directly or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

(c) The State public health agency may require individuals within the public health system to meet minimal training requirements to assist the individual in providing essential public health services and functions.

(d) The State public health agency may provide incentives to meet performance management or training requirements, including:

(1) Organizational accountability awards.

(2) Accreditation recognition for public health agencies or their contractors or volunteers.

(3) Certification or credentialing titles or recognition for individuals.

(4) Other career development initiatives, including financial benefits.

(e) The State public health agency shall:

(1) Adopt a framework for the evaluation of the performance of the local public health agency workforce.

(2) Develop standards to consistently evaluate the effectiveness and delivery of training programs, continuation education, and other tools.

(3) Consistently evaluate performance management and training programs, continuing education, and other tools pursuant to these frameworks or standards.

"**§ 130A-2.6. Local public health plans.**

(a) Every county, through its local public health agency, shall provide for the development, review, and approval of a local public health plan consistent with the comprehensive State public health plan required under G.S. 130A-2.7. The local public health plan shall address how the local public health agency will coordinate with the State public health agency and others within the public health system to accomplish goals and priorities identified in the comprehensive State public health plan. The local public health plan shall cover five years and shall be reviewed annually. Future plans shall be developed every five years. Prior to the approval of the local public health plan, the local board of health and the board of county commissioners shall hold a public hearing with notice published at least 10 days before the hearing. In addition to the items listed in G.S. 130A-2.7, the local public health plan shall include the following:

(1) Description of the demographics and health indicators of the population being served by the local public health agency.

(2) Description of the numbers and types of professionals in the local public health workforce.

(3) Description of the local public health workforce training needs.

(4) Description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) Description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and are of the highest quality possible.

(6) Description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) Other matters determined by the Secretary to be necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

(b) The State public health agency shall provide technical assistance to local public health agencies that request assistance and shall otherwise work with local public health agencies to generate the plan."

"**§ 130A-2.7. Comprehensive State public health plan.**

(a) The State public health agency shall develop a comprehensive public health plan ("Plan") that assesses and sets priorities for the State public health system based on local public health plans developed and submitted in accordance with G.S. 130A-2.6. The State public health agency shall develop the Plan in consultation with representatives from its public and private sector partners. The Plan may rely on existing or available surveillance data or other information available to the State public health agency, as well as national guidelines or recommendations concerning public health outcomes and improvements. The Plan shall cover five years and shall be reviewed annually. Future Plans shall be developed every five years. Prior to the adoption of the Plan, the State public health agency shall hold public hearings around the State with notice published at least 10 days before each hearing. The Plan shall include the following:

(1) Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

(2) Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

(3) Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

(4) Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

(5) Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies and schedules for meeting these goals.

(6) Strategies for coordinating service delivery within the public health system.

(7) Measurable indicators of effectiveness and success.

(8) Identification of public and private sector partners.

(b) The State public health agency shall submit a copy of the comprehensive State public health plan required under this section annually to the Governor and the General Assembly upon its convening or reconvening, including any recommendations for legislative amendments.

SECTION 4. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the comprehensive State public health plan and the local public health plans:

(1) Ensure that local public health plans required under G.S. 130A-2.6 are completed and submitted no later than July 1, 2004.

(2) Develop the State comprehensive public health plan in accordance with G.S. 130A-5.2 not later than January 1, 2005.

(3) In consultation with local public health agencies, the State public health agency shall develop and administer an accreditation program not later than January 1, 2005. The program shall include criteria that measure the local public health agencies capacity to provide, in collaboration with public and private sector partners, all essential public health services and functions listed in G.S. 130A-2.6 in a manner that promotes quality and financial sustainability.

(4) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary and identify rules that are inconsistent with this act.

(5) Review all oversight and monitoring functions currently implemented by the Department with respect to the public health system to determine the effectiveness of the activities on achieving the intent of the act; and improve the oversight and monitoring functions and activities, if necessary; identify areas where additional training is needed and provide it.

(6) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(7) Develop format and required content for local public health plans.

(8) Develop a method for Departmental evaluation of local public health plans.

(9) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health plans.

(10) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement public health infrastructure reform no later than October 1, 2004.

(11) In consultation with officials from the North Carolina Boards of Health, the North Carolina Association of Local Health Directors, and the North Carolina Association of County Commissioners, develop and implement a consolidation plan based on the accreditation criteria developed pursuant to G.S. 130A-2.5. The consolidation plan shall be

developed no later than January 1, 2005 and shall be fully implemented no later than July 1, 2006.

SECTION 5. There is appropriated from the General Fund to the Department of Health and Human Services the sum of twenty-five thousand dollars ($25,000) for the 2003-2004 fiscal year. These funds shall be used by the Department of Health and Human Services to conduct the public hearings required by this Act.

SECTION 6. Section 5 of this act becomes effective July 1, 2003. The remainder of this act is effective when it becomes law.

SENATE BILL 672:
Strengthen Public Health Infrastructure

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Senator Hartsell
Date:	May 27, 2003	**Summary by:**	Sandra Alley
Version:	S672-CSSP-8[v.3]		Committee Counsel

SUMMARY: ***SB 672 repeals G.S. 130A-1 and adds new G.S. 130A-2 through –2.7 to (1) declare mission of state and local public health system; (2) specify responsibilities of state and local governments in the delivery of public health services; (3) require collaboration with private sector partners; (4) define essential public health services and functions; (5) specify specific duties of state agencies in improving public health infrastructure and its workforce (including establishment of certification or accreditation programs); (6) require state health agencies and counties to develop comprehensive public health plans, with specific components for the State plan and local plans specified in the bill; (7) requires DHHS to develop and implement a consolidation plan based on accreditation criteria and local health agencies ability to deliver essential health services by Jan. 1, 2005; (8) Appropriates $1 million to DHHS from General Fund for fiscal 2003-04 to provide incentives to local governments to consolidate local health agencies into regional health departments; (9) rewrites G.S. 130A-5(3) to clarify that the Secretary of DHHS is responsible for carrying out the State public health plan.***

Section 6 of this bill becomes effective July 1, 2003. The remainder of the bill becomes effective when it becomes law.

CHANGES UNDER THE PCS:

SECTION 4. Reduces appropriation to DHHS from $1 million to $25,000 and directs DHHS to use these funds to hold public hearings rather than to create incentives for local health departments to consolidate.

Requires DHHS to consult with State and local health agencies, the North Carolina Local Boards of Health, the North Carolina Association of Local Health Directors and the North Carolina of County Commissioners to develop accreditation programs by January 1, 2005.

Eliminates amendments to G.S. 130A-5 which would have directed the Secretary of the Department of Health and Human Resources to carry out the State public health plan and authorized the Commission to adopt rules necessary to carry out the plan.

Changes the deadline for the development of local public health plans from January 1, 2004 to July 1, 2004.

CURRENT LAW: Under G.S. 130A-1.1 the mission of the State public health system is to promote and contribute to the highest levels of health possible for the people of North Carolina by: 1) preventing health risks and disease; 2) Identifying and reducing health risks and diseases; 3) Detecting, investigating, and preventing the spread of disease; 4) Promoting health lifestyles; 5) Promoting a safe and healthful environment; 6) Promoting the availability and accessibility of quality health care services through the private sector; and 7) Providing quality health care services when not otherwise available. G.S. 130A-1.1 defines "essential public health services" as those services that the state shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North

Carolina. In addition G.S. 130A-1.1 states that the Departments of Environment and Natural Resources and Health and Human Services shall attempt to ensure that certain essential public health services are available and accessible to all citizens of the state and shall account for the financing of these services which include, generally, 1) Health Support; 2) Environmental Health; and 3) Personal Health.

Local public health services are provided by counties (G.S. 130A-33.51). A county may operate a county health department, establish a consolidated human services agency pursuant to G.S. 153A-77 (Mecklenburg and Wake Counties only), participate in district health department, or contract with the state for the provision of health services.

Currently there are 85 public health departments operating in North Carolina.

BILL ANALYSIS:

Section 1. repeals G.S. 130A-1.1. which contains the current mission statement.

Section 2. adds additional definitions to G.S. 130A-2. The intent of the new sections is to clarify State policy regarding the mission of the public health system, what are "essential public health services and functions", who provides these services and functions, and who is accountable. For example, the new provisions clarify that:

- State and local public health agencies must work in concert with other public agencies and private organizations, institutions, persons, and businesses to protect and promote the public's health.
- The mission of the State and local public health agencies is to (1) provide leadership, (2) provide essential services, (3) encourage collaboration among public and private sector partners, and (4) seek funding from public and private sources.
- State and county governments are responsible for assuring that the State and local public health agencies and their public and private sector partners accomplish the mission of public health.
- Essential services and functions include: monitoring health status of communities, diagnosing and investigating public health problems and hazards, health education, promoting health care access, quality and availability, research, enforcement of public health laws, ensuring workforce competency, and collaborating with public sector partners to promote access to preventive and primary health care.

Section 3.: adds G.S. 130A-2.4 to direct State and local public health agencies to:

- Work with their public and private sector partners to enhance the leadership and organizational management skills of the public health workforce.
- Ensure that the public health workforce receives necessary leadership and management training to enable the workforce to set goals and priorities to effectively accomplish the essential public health services and functions.

Section 3 also adds G.S. 130A-2.5 to direct State public health agency (includes DHHS and the Commission for Health Services) to establish workforce performance standards, including:

- National Public Health Performance Standards.
- Accreditation of local public health agencies (only those agencies capable of providing essential public health services and functions shall be accredited.
- Certification of credentialing of the public health workforce.

The State public health agency is also directed to:

- Make available continuing education programs.
- Provide incentives for the workforce to meet performance standards and training requirements.

Evaluate the performance of the local public health workforce.

Section 3 adds G.S. 130A-2.6 and 130A-2.7 to require State and local public health agencies to develop comprehensive five-year public health plans that assess and set priorities for the public health system.

Key elements include:

- Local plans are developed by county governmental entities, through the local public health agencies and its public and private sector partners.
- Local plans must identify local goals and priorities and be consistent with the State public health plan.
- Local plans must address local needs and how the local agency will be held accountable for providing essential services and functions and expenditures of revenue.
- Local plans must be approved and submitted by July 1, 2004.
- State plan must be developed in consideration of local plans and submitted not later than January 1, 2005. The ***purpose*** of the State plan is to:
    - Identify public health problems, disparities, threats;
    - Identify specific at-risk populations; to set goals for targeting essential public health services and functions;
    - Set goals for increasing the effectiveness and efficiency of the public health system; and
    - Identify public and private sector partners.

- Amends Part 1 of Article 1 of Chapter 130A by adding a public health mission statement that applies to State and local health agencies. The mission statement says the policy of the state is to protect and promote the health of the public to the greatest extent possible.
- States that it is the responsibility of the State and counties to assure the success of public health systems. It also sets up guidelines for State and local government to contract with or otherwise work with the private sector to deliver public health services.
- Outlines the essential public health services and functions that State and local health agencies are expected to provide, in collaboration with public and private sector partners.
- Directs the Secretary of Health and Human Services to coordinate State and local public health agencies and their public and private sector partner to help strengthen and maintain stability of the public health infrastructure.
- Directs the State public health agency to manage the State and local public health workforce performance related to public health infrastructure and capacity, processes, and outcomes and the State and local level.
- Directs the State public health agency to establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. This would include accreditation of local public health agencies and certification of public health workers.
- Directs counties, through their local public health agencies, to set up local public health plans consistent with the State public health plan.

- Directs that State public health agency to develop a comprehensive State public health plan ("the Plan") that assesses and sets priorities for the State public health system based on the local health plans as described above.

Section 4. rewrites G.S. 130A-5(3), which governs the duties of the Secretary of Health and Human Services. Under the revision it is the Secretary's responsibility to develop and carry out the comprehensive State public health plan pursuant to G.S. 130A-2, and the Commission for Health Services is granted rulemaking authority to carry out the Plan.

Section 4. also requires the department to conduct performance management and training programs and evaluations to improve the State and local public health workforce, and to review the public health system at least every five years to recommend changes in its structure in order to improve public health outcomes.

The PCS eliminates Section 4 of the bill.

Section 5. directs the Department of Health and Human Services to develop and implement a consolidation plan based on the accreditation criteria developed pursuant to G.S. 130A-2.5 and a local health agency's ability to provide all essential health services in a financially sustainable manner. The consolidation plan shall be developed no later than January 1, 2005 and shall be fully implemented no later than July 1, 2006.

CHANGES UNDER THE PCS:

NEW SECTION 4. Reduces appropriation to DHHS from $1 million to $25,000 and directs DHHS to use these funds to hold public hearings rather than to create incentives for local health departments to consolidate. Requires DHHS to consult with State and local health agencies, the North Carolina Local Boards of Health, the North Carolina Association of Local Health Directors and the North Carolina of County Commissioners to develop accreditation programs by January 1, 2005.

Eliminates amendments to G.S. 130A-5 (contained in the original Section 4 above) which would have directed the Secretary of the Department of Health and Human Resources to carry out the State public health plan and authorized the Commission for Health Services to adopt rules necessary to carry out the plan.

Changes the deadline for the development of local public health plans from January 1, 2004 to July 1, 2004.

BACKGROUND:

In the 1990's there was a growing awareness among some public health leaders that significant adjustments were needed in the organization, financing and provision of public health in North Carolina. At least eight major studies were conducted to determine how local public health should adapt to meet the new challenges to protect the public's health.

The studies demonstrated an awareness of the need for change, an ability to bring community leaders together, an ability to focus on solutions rather than problems, and a need to develop action plans. Thus far, no significant actions have taken place as a result of these efforts.

VISITOR REGISTRATION SHEET

Senate Health & Human Resources — **June 4, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stan Mitchell	Novartis
Jack Griffith	Pender Co. Health Dept
John Roase	Sampson Co. Health Dept.
Kurt Weber	The North Carolina Eye Bank
Jane Smith	NCDHHS
Chris O'Meara	N.C. Healthy Start Foundation
Janice Freedman	NC Healthy Start Foundation
Angie Harris	Manpi Taylor
John Cyrus	NC State Grange
John Bowdish	AstraZeneca
Brian Shaw	AZ

VISITOR REGISTRATION SHEET

Senate Health & Human Resources — **June 4, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Lewis	Planned Parenthood
Kama Chapman	PPHS
Jessica Dawdy	Covenant w/ NC's Children
[signature]	114C Warlow Dr Kernersville N.C.
Charlene P. Durkins	Sec. of State
Charlie Chrisawn	Poyner + Spruill LLP
DAVID BARNES	Poyner + Spruill
Benny Scarboro	NCHC
[signature]	NCDS & NIPTA
[signature]	NASW
Patrice Roesler	NCACC

VISITOR REGISTRATION SHEET

Senate Health & Human Resources — **June 4, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Audrey H. Galloway	MDN
Jerry L. Parks	Albemarle Regional Health Services
Leah Devlin	DHHS - DPH.
Deborah Rose	NCPHA / NCALHD
Jim Bolin	NCALHD / Health Dir. Edgecombe Co
Louis Latour	Wilson Co. Dept. of Public Health / NCALHD
Tim Green	NCALHD Alamance Co. Health Dept

AGENDA

JOINT HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 11, 2003 at 11:00 A.M.
Room 643, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Health and Human Services Secretary Carmen Hooker Odom will report to the Committees on the status of health in North Carolina.**

III. **Other Business**

IV. **Adjournment**

JOINT SENATE AND HOUSE OF REPRESENTATIVES
HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 11, 2003
11:00 A.M.
Room 643, Legislative Office Building

MINUTES

The Senate and House of Representatives held a Joint Health and Human Resources Committee meeting at 11:00 A. M. on Wednesday, June 11, 2003 in Room 643 of the Legislative Office Building. Twenty members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham recognized his Co-Chair Senator William Purcell. He also recognized the House Committee's Co-Chairs, Verla Insko and Carolyn Justus. The House and Senate Pages were introduced.

Senator Bingham asked if everyone had the report, ***The Health of North Carolinians: A Profile***, to be discussed by the Secretary of the NC Department of Health and Human Services. Secretary Carmen Hooker Odom was introduced. Her remarks are attached. After the presentation Senator Bingham opened the floor for questions.

Senator Forrester asked about Mental Health on page 11, it being very difficult to get a handle on the number of Mental Health patients in NC. Secretary Odom stated they know how many people they are serving but it is hard to have a number for the ones that are untreated. Senator Forrester was also concerned about suicide, if 1,000 people die in NC from suicide it looks like it would be an epidemic as if it were a disease. Dr. Leah Develin, stated it is a tremendous problem and they have suicide prevention work groups and have developed a teen suicide prevention plan.

Senator Queen asked how do they shift funds to preventive health from public health care. Secretary Odom stated that their strategy was to hang on and survive the difficult budgetary times. Senator Queen stated there are a lot of drivers selling services and providing services but not many interest groups in prevention. It is not spending money so there are no profits except in our society the savings long term, so it seems we have to have a very strong and well thought out preventive policy. It is not going to be driven by the private sector.

Representative Wright wanted to thank the department for their work on this report and the document released in February, Health Disparity Report. In regards to HIV/AIDS what steps are you taking in the department to move the federal poverty guide lines from 125% to a more acceptable number nationally. NC is the only state that remains well below the average. Secretary Odom stated it is really shameful that NC is the lowest state in the entire country in terms of eligibility level. The first thing to do is remove the language in both budgets that prevents the department from going over 125%. They are working very hard at the Federal Level to get a rearrangement of the formula for the distributions of funding for HIV/AIDS so there will be more funding in the rural areas verses urban states.

Representative Bernard Allen is very disturbed about Table 3 on page 15, African Americans leads every single category. He was very concerned about the increase in AIDS/HIV. Secretary Odom pointed out that she learned from the Black Caucus that their department had not traditionally had a really good relationship with community based organization. There has got to be a good partnership with the community based organization, who are on the streets 24 hours per day 7 days per week and 365 days per year. It can not be done top down from Raleigh and any ideas would be appreciated.

Senator Bingham thanked Secretary Odom and her staff and the meeting adjourned at 12:05.

Senator Stan Bingham, Co-Chair

William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

Carmen Hooker Odom
Remarks to the House Committee on Health and Senate Committee on Health and Human Resources
Wednesday, June 11, 2003

Good morning Chairman Purcell, Chairman Bingham, Madame Chair Insko and Madame Chair Justice and other members of the House and Senate committees:

More than 200 years ago, Benjamin Franklin wrote that for the "want of a nail" the horseshoe was lost, the horse went lame and the battle was lost. In other words, the key to victory lay in preventing problems before they occur rather than trying to solve them afterwards.

Franklin's lesson shouldn't be lost on us. North Carolina has made significant and fundamental strides in improving public health across the state in the past year. But even as we continue our efforts to reduce particular health problems . . . we must turn our attention and emphasis away from ***responding*** to health problems and toward ***preventing*** health problems.

In fact, the watchword for North Carolina's public health in the coming years must be prevention.

2002 proved to be a rewarding year for North Carolina public health. We made significant gains in public health preparedness while moving forward on other critical public health issues. The key to our success – as always – has rested on the strong partnership between the state Division of Public Health, local public health departments, health care providers, and other community health stakeholders.

While we have made great strides in addressing the threat of bioterrorism, this strengthened capacity is critical in enabling our public health system prepare for a wide variety of threats – ranging from hurricanes to the most recent worldwide public health threat involving SARS.

And while not neglecting those health issues that get most of the public and media attention, we need to build the same capacity to address the leading causes of death among our citizens, such as cardiovascular diseases, cancer, diabetes and stroke. We must also maintain and strengthen the major investments we have already made in maternal, infant and child health.

We are committed to major system improvements and accountability for outcomes that will assure that public health responds as effectively as possible as a state and local system. We must ensure that our society, its opinion leaders and decision-makers are not allowed to forget the importance of protecting and improving the public's health by ensuring a sound infrastructure.

As I stated at the outset, North Carolina must move from ***responding*** to health issues – which is costly in terms of dollars, pain and suffering, and premature death – toward preventive strategies with its lower cost and dramatic impact on improved quality of life for families and communities. We have much work to do in this area.

Health Behavior

In North Carolina, about 53 percent of deaths are preventable each year. Medical costs associated with tobacco use, physical inactivity, and poor nutrition are estimated to cost more than $6 billion per year in North Carolina. The obesity rate in North Carolina has increased 77 percent since 1990.

Poor health is highly associated with living in poverty. African Americans are 2.7 times as likely to live in poverty as whites.

Tobacco Use

Tobacco still leads as the number one cause of ***preventable*** deaths in North Carolina. Currently 34.5 percent of children in grades 9-12 indicate that they use tobacco. The addiction begins often by age 14 – if we can get people past age 21 tobacco free, they are not likely to be tobacco users. We know the science-based strategies that work – such as the creation of tobacco free environments, effective public awareness campaigns, and making more cessation services available.

Obesity

We have finally recognized and begun to address the problem of overweight and obesity adults and children in North Carolina. By 18 years of age approximately 25 percent of youth are overweight or obese and eventually 60 percent of adults are overweight. There was a 40 percent increase in overweight and obese children seen in local health departments aged 5-11 years between 1995-2000.

Overweight and obesity are major contributors to many preventable causes of death and raise the risk of developing high blood pressure, high cholesterol, diabetes, heart disease, stroke, cancer and other illnesses. In addition, Type II diabetes formerly seen only in adults is now being diagnosed in children. The underlying risk factors are often a combination of physical inactivity and poor diet.

Cardiovascular disease is the leading cause of death in North Carolina accounting for nearly 40 percent of all deaths, killing 26,000 people in the state annually. The *Eat Smart Move More Plan* and the *Moving Our Children to a Healthier Weight Initiative* were both launched in 2001, offering comprehensive recommendations for community action to prevent overweight and obesity.

Infant, Child, and Adolescent Health

The rate of child deaths has decreased 33 percent since 1987. Infant mortality has decreased 41 percent since 1980. Teen pregnancy has declined more than 30 percent in the last decade. On the other hand, the percentage of children with asthma has increased with 17 percent now diagnosed with the disease.

But children also face perils beyond disease. We have noted statewide increases in the number of child abuse and neglect cases. Many cases are in situations that couple domestic violence and substance abuse.

The Child Well-Being and Domestic Violence Task Force that Chief Justice I. Beverly Lake and I co-chaired looked at the effects on children raised in violent homes. The task force made recommendations to protect children who are exposed to domestic violence – as well as adopting shared principles and common protocols for the courts, public safety offices, child welfare protection agencies and domestic violence advocates.

In 2001, 7.5 percent of North Carolina children had no health insurance. Medicaid and Health Choice provide insurance coverage for many lower income children. NC Health Choice has offered health insurance to low-income children since 1998. Over 99,556 children were enrolled in NC Health Choice as of June 1, 2003.

Child immunization rates are high in North Carolina with 80 percent of children having appropriate immunizations in 2001 as compared to the national rate of 74 percent. This is due, in large part, to the General Assembly's support and championship of North Carolina as a universal vaccination state, where all of our children are provided vaccines.

As stated before, overweight and obesity has become a serious health problem among children in North Carolina. One-fourth of children ages 12-18 are overweight. Thirty-six percent of high school students reported no regular, vigorous physical activity each week and only 18 percent reported eating fruits and vegetables on a regular basis.

We must begin to teach children early about the importance of exercise through such programs as Governor Easley's More at Four Program and Smart Start. There is also a serious lack of school heath services in North Carolina.

While there are many aspects of a coordinated school health program that do well, one glaring example of our need to improve children's health services in school is in the ratio of school nurses to children. The national standard of nurses to students 1:750, however, in North Carolina the ratio is 1:2000. The lack of school health services represents a devastating missed opportunity to improve the health of children and help ensure their academic success.

Since 1990, adolescent pregnancy rates have declined by more than 30 percent in North Carolina. North Carolina has announced its lowest teen birth rate in more than two

decades. In 2001, the state's pregnancy rate for all 15-19 year old girls was 69.3 per 1,000, down 9 percent from the 2000 rate of 76.1 per 1,000.

Minority Health and Disparities

Minority males have the lowest life expectancy of any group, 68.0 years at birth. In spite of declines in infant mortality for all racial groups, African-American infants are still more than twice as likely to die at birth as white infants. African Americans are also more likely to suffer from a variety of illnesses, accounting for higher mortality than whites.

Between 1990 and 2000, North Carolina experienced the greatest percentage growth in Latino population of any state in the U.S. Nearly 50 percent of all Hispanic deaths are due to fatal injuries. Native Americans also suffer from higher death rates than whites and have a very high percentage of persons with no health insurance (25 percent).

I earnestly believe that we as a state must dedicate the necessary resources – both human and financial resources – in order to reduce and eventually eliminate health disparities among our minority populations. I urge and enjoin the membership of the General Assembly to do all within your power to move health disparities to a higher rung on the priority ladder.

Seniors

Chronic diseases are responsible for 65 percent of all deaths in North Carolina – resulting in approximately 45,000 deaths each year. While death itself is unavoidable, it may often be postponed if chronic health conditions and risky behaviors are prevented or controlled, especially among our senior population.

Many of the leading causes of death for North Carolinians – including heart disease and diabetes can be prevented.

North Carolina is also moving to meet the prescription needs of the state's senior population. The Senior Care Program was created to help low-income seniors who are coping with the rising costs of prescription medicine. Senior Care offers coverage for 60 percent of the first $1,000 worth of the costs for prescription drugs for the treatment of cardiovascular disease, chronic obstructive pulmonary disease and diabetes.

One or more of these diseases affects about 75 percent of North Carolina's elderly with about 150,000 seniors estimated to be eligible for this service. And the Division continues to promote awareness and education about arthritis and osteoporosis, which are leading causes of disability in the elderly.

As of June 6th, 16,752 Senior Care applications had been approved. The state's portion of cost per prescription is $44. Each utilizing member has received coverage for 2.2 prescriptions per month. We are preparing to send applications 24,000 dual eligibles

who are not already enrolled. Word of mouth is far and away the most frequent way that seniors report having heard about the program.

Mental Health

We continue to proceed with our effort to update the state's metal health delivery system. The *Blueprint for Change – North Carolina's State Reform Plan for Mental Health, Developmental Disabilities and Substance Abuse Services* constitutes the first substantial overhaul of the state's mental health system since 1974.

As you well know, the state spends more than $1.8 billion dollars every year to provide mental health, developmental disabilities and substance abuse services to over 300,000 citizens.

Each July, the state updates the plan reflecting changes and input it has received over the past year. We are in the process now of receiving and incorporating ideas, suggestions and comments concerning the state MH/DD/SAS plan from people across the state. We will continue to collect public comments through June 20, and then release an updated plan by July.

HIV/Sexually-Transmitted Disease and Communicable Diseases

North Carolina's syphilis rate is higher than the national rate, despite the fact that the syphilis rate in our state has been declining in the last few years. North Carolina's gonorrhea and chlamydia rates are also higher than the national average.

There was a 16 percent increase in new AIDS cases in North Carolina last year. This increase in new AIDS cases reflects a regional trend in which seven of the 10 states with the highest AIDS case rates are in the South. While the South represents a little more than 33 percent of the U.S. population, it now accounts for about 40 percent of the estimated people living with AIDS and 46 percent of the new AIDS cases.

Estimates are that currently at least 21,000 North Carolina residents are living with HIV/AIDS. Approximately 44 percent of new HIV cases were among African American males, 24.5 percent among African American females, and 19.5 percent were white, Non-Hispanic males. While many cases are reported without a transmission mode, about a third of all new cases indicate heterosexual transmission.

North Carolinians experience a much higher rate of sexually transmitted diseases compared with the rest of the country. North Carolinians have higher rates of congenital syphilis, primary and secondary syphilis, gonorrhea, chlamydia, and HIV/AIDS than other Americans.

Health Care Access

North Carolina has about the same percentage of people with no health insurance as the nation (14.2 percent versus 14.5 percent). Minorities are twice as likely as whites (26 percent versus 13 percent) to have no health insurance in North Carolina.

Medicaid has become a significant provider of health care for poor people in North Carolina. In 2002, the average monthly enrollment in Medicaid was 989,863, three times the number in 1989.

About 33 percent of all North Carolinians live in rural areas, compared with 20 percent nationally. There is an unequal distribution of health professionals in North Carolina. In 2001, 14 counties did not have any physicians attending births. North Carolina ranks 43rd in the nation in the number of Medicaid participation by dentists.

Public Health Preparedness

Since January of 2002 the strategic investments that have been made in partnership with local health departments, hospitals, the UNC School of Public Health and others include the establishment of the state Office of Public Health Preparedness and Response as well as the seven Public Health Regional Surveillance Teams.

The Division has also strengthened its epidemiology capacity recruiting additional experts and strengthening relationships with Department of Agriculture, universities and private labs. Because of its vital link in the state's ability to detect and respond to a natural or intended threat, the NC State Laboratory of Public Health is expanding its capacity centrally and regionally.

Also, the 2002 General Assembly passed the Public Health Readiness Act, which better defines the state's public health laws and ensures that state and local public health officials have the appropriate authority to protect the public's health. We are nearing completion of the first phase of the North Carolina smallpox plan. We are entering the West Nile season and are helping the public become aware of the risk of SARS in our community.

Summary

Chairman Purcell, Chairman Bingham, Madame Chair Insko and Madame Chair Justice and other members of the House and Senate committees – I appreciate the opportunity to talk about the overall state of public health in North Carolina in 2002.

While North Carolina continues to fall in the lower state rankings in most state health indicators, we have made significant strides in addressing health issues such as SARS and bioterrorism. We need, however, to build our capacity for responding to chronic diseases, the leading causes of death, and shore up our children and family services. We also must focus efforts on special populations – such as minorities, seniors,

and people living in rural areas – whom suffering from disproportionate number of health problems.

Most health issues facing North Carolina are preventable, if we make it our priority to invest in prevention and to deal with the socio-economic factors that impact health. You heard me speak today of what we've accomplished so far . . . think of the billions of dollars we could save in deferred medical costs as well as the lives saved if we learn the lesson that Benjamin Franklin tried to teach so long ago and "find the nail that saves the shoe that saves the horse and wins the battle."

Thank you.

###

VISITOR REGISTRATION SHEET

Joint Health and Human Resources — **June 11, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stella McKenzie	NC DHHS
Daphne Lyon	OSBM
Patricia Yarborough	APPCNC / Friends of Residents in Long Term Care
Kim Lang	NCAC DSS
Dan Hudson	Durham Co. DSS
Caroline Smith	" " "
~~REBECA~~ GONZALEZ-PLACIO	NC Justice Center
Audrey Galloway	MOD
Helen Lyons	Mecklenburg County
Butch Gunnells	NCSDA
Ann Lucas	DHHS-OMH/DD/SA
ANN LUCAS	OUHS

VISITOR REGISTRATION SHEET

Joint Health and Human Resources — **June 11, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Donovan	NAMI
Shawn Doorley	Sen. Forrester
Jessica Dowdy	Covenant w/ NC's children
Abby Emanuelson	Nat'l MS Society
Karina Chapman	PPHS intern
Brian Lewis	Planned Parenthood Health Sys.
Paige Johnson	Planned Parenthood of Central NC
Lance Mangum	Governor's office (Intern)
Jud Widall	NC Comm. Support Provider Council
A.A. Adams	Victim Advocate
J. Craig Lee	UHS

VISITOR REGISTRATION SHEET

Joint Health and Human Resources — **June 11, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Garvin	IAF
Edna Campos	El Pueblo
Andrea Bazán Manson	El Pueblo
Roslyn Savitt	NC Child Care Coalition
John Bowdish	AstraZeneca
Bill Rustin	ACP
John McHugh	Gov Office
Camille Stell	KCLH
Amy Dobson	NC Statewatch
Jason Hsieh	Durham Cty Health Dept
Sarah Gonzalez	Durham Co Health Dept.
Jennifer Prish	Durham Co Health Dept

VISITOR REGISTRATION SHEET

Joint Health and Human Resources — **June 11, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
SHIRISH DEVASTHALI MD	North Carolina Medical Society & Blood & Cancer Clinic, 2125 Valleygate Dr, Fayetteville NC 28304
CHAD Essick	Edmisten & Webb
John Cyrus	nc State Grange
Eric Mazur	AMP
Bill Scoggin	KCCH
Crissy Porter	Smith Anderson
Amy Jo Hare	NCMS
Lu Ann Coe	Psych. Assoc.
Martha Lawrence	YAJD
Joyce Peters	NAAssoc of Moms1
	NCAHP

17

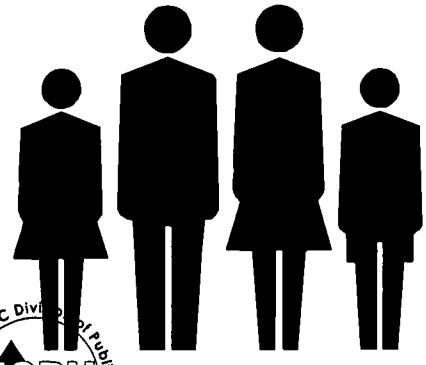
VISITOR REGISTRATION SHEET

Joint Health and Human Resources — **June 11, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mari Lewis	GSK
Joanne Stevens	nursing + NCCRSA
[illegible]	WRP
Priscy Harrison	Brunswick NC
Anne Dixon	[illegible]
Leanne Tunnicliff	NCSBA
Dr. Al Wentzy	DSS Northampton Co
BB Hedrick	NCSPC

The Health of North Carolinians: A Profile



NC Department of Health and Human Resources
Division of Public Health
State Center for Health Statistics
1908 Mail Service Center
Raleigh, North Carolina 27699-1908
www.schs.state.nc.us/SCHS/

April 2003

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 18, 2003 at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- HB 815 Detox Facilities Not Subject to CON, Representative Alexander

III. Other Business

IV. Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 18, 2003
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:30 A.M. on Wednesday, June 18, 2003 in Room 544 of the Legislative Office Building. Seven members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Purcell introduced Representative Martha Alexander to present her bill, HB 815, *Detox Facilities Not Subject to CON*, to the committee. Senator Malone stated that he wanted to be sure that this bill would have no effect on facilities now operating. Jim Klingler of the Research Staff assured him that this bill would not do that. Representative Alexander said that this bill had no opposition. Senator Hartsell moved for a favorable report with a recommended referral to the Appropriations Committee. The motion passed.

The meeting adjourned at 11:45 A.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH AND HUMAN RESOURCES COMMITTEE REPORT

Senator William Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, June 19, 2003

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

FAVORABLE

H.B. **815** Detox Facilities Not Subject to CON.
Sequential Referral: None
Recommended Referral: Appropriations/Base Budget

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 815

Short Title:	Detox Facilities Not Subject to CON.	(Public)
Sponsors:	Representatives Alexander; and Insko.	
Referred to:	Health.	

April 1, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT FACILITY TO PROVIDE THAT SOCIAL SETTING DETOXIFICATION FACILITIES AND MEDICAL DETOXIFICATION FACILITIES ARE NOT CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS AND TO AMEND THE DEFINITION OF CHEMICAL DEPENDENCY TREATMENT BED TO PROVIDE THAT BEDS LICENSED FOR DETOXIFICATION ARE NOT CHEMICAL DEPENDENCY TREATMENT BEDS FOR THE PURPOSES OF CERTIFICATE OF NEED REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176(5a) reads as rewritten:

"(5a) "Chemical dependency treatment facility" means a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of chemically dependent or substance abusing persons and related services. The facility or unit may be:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5, Chapter 131E, of the General Statutes,

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C,

c. A freestanding facility specializing in treatment of persons who are substance abusers or chemically dependent licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C; and may be identified as

"chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance abuse, alcoholism or drug abuse facilities," ~~"social setting detoxification facilities" and "medical detoxification facilities,"~~ or by other names if the purpose is to provide treatment of chemically dependent or substance abusing persons, but shall not include social setting detoxification facilities, medical detoxification facilities, halfway houses or recovery farms."

SECTION 2. G.S. 131E-176(5b) reads as rewritten:

"(5b) "Chemical dependency treatment beds" means beds that are licensed ~~for detoxification or~~ for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance abuse are chemical dependency treatment beds. Chemical dependency treatment beds shall not include beds licensed for detoxification."

SECTION 3. This act is effective when it becomes law.

HOUSE BILL 815:
Detox Facilities Not Subject to CON

BILL ANALYSIS

Committee:	Senate Health & Human Resources	**Introduced by:**	Rep. Alexander
		Summary by:	Dianna Jessup Committee Counsel
Date:	June 18, 2003		
Version:	First Edition		

SUMMARY: ***House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from Certificate of Need requirements. The act would become effective when it becomes law.***

CURRENT LAW:

Certificate of Need: State law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment unless the provider obtains a Certificate of Need from the Department of Health and Human Services (DHHS). A Certificate of Need is also required before beginning to offer certain health services. The purpose of the CON is to control health care costs by preventing the unnecessary duplication of medical facilities and services and to help ensure the geographic distribution of health care facilities and services. All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing homes, adult care homes, kidney disease treatment centers, intermediate care facilities for the mentally retarded, rehabilitation facilities, home health agencies hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before developing new facilities or offering new services.

Chemical Dependency Treatment Facilities: Chemical dependency treatment facilities are currently subject to CON requirements. G.S. 131E-176 defines a "chemical dependency treatment facility" to be a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, therapy, and related services. "Halfway houses" and "recovery farms" are not considered "chemical dependency treatment facilities" for CON purposes.

Social Setting Detoxification Facilities and Medical Detoxification Facilities: Social setting detoxification facilities and medical detoxification facilities are considered "chemical dependency treatment facilities" under G.S. 131E-176. They are licensed under Article 2 of Chapter 122C of the General Statutes. Services provided by social setting detoxification facilities are not eligible for reimbursement under Medicaid. Medicaid does cover medical detoxification if provided at an acute care hospital. Other State funds are available for social/nonmedical detoxification. These facilities do not engage in treatment for substance abuse.

BILL ANALYSIS: House Bill 815 would exempt social setting detoxification facilities and medical detoxification facilities from CON requirements, the same as halfway houses and recovery farms. Persons who want to offer or develop these facilities would not have to seek the prior approval of DHHS. Licensing requirements would still apply. The act would become effective when it becomes law.

H815-SMSW-002

Amy Compeau, Research Assistant, contributed to this summary.

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: House Bill 815 (First Edition)

SHORT TITLE: Detox Facilities Not Subject to CON

SPONSOR(S): Representatives Alexander and Insko

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
REVENUES					
Federal Medicaid	$236,477	$236,477	$236,477	$236,477	$236,477
EXPENDITURES					
State Medicaid Share	$120,295	$120,295	$120,295	$120,295	$120,295
Local					
County Medicaid Share	$21,228	$21,228	$21,228	$21,228	$21,228

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has stated that it will cover the fiscal impact to the Medicaid budget in the Division of Medical Assistance through cost savings associated with the downsizing of the state psychiatric hospitals. The necessary amount would be transferred from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services budget to the Division of Medical Assistance budget.

EFFECTIVE DATE: When the bill becomes law.

BILL SUMMARY: House Bill 815 amends G.S. 131E-176 to exclude social-setting detoxification and medical detoxification facilities from certificate of need requirements.

By removing these two types of facilities, the development of detoxification facilities that are independent of general and psychiatric hospitals would no longer require certificates of need from the Department of Health and Human Services (DHHS). As a result, there would be no state regulation of the number of freestanding detoxification facilities in the State, but DHHS would continue to license and regulate the operation of such facilities.

Residential treatment facilities for chemical dependent persons would still be subject to certificates of need.

ASSUMPTIONS AND METHODOLOGY: In developing the fiscal impact of the proposed bill, three general issues were considered: (1) the anticipated increase in the Medicaid program; (2) the net fiscal impact to the State's Alcohol and Drug Abuse Treatment Centers (ADATC's), and; (3) the net fiscal impact to Division of Facility Services.

Medicaid

Non-hospital medical detoxification is a reimbursable service for persons eligible for Medicaid. The removal of the certificate of need requirement is expected to increase the availability of detoxification beds throughout the State. According to DHHS, these additional beds coupled with the existing need for services should result in increased Medicaid expenditures.

In calculating the impact to the Medicaid budget, DHHS developed the following assumptions:

- The number of individuals who have unmet detoxification needs is 3,600 per year.
- 33.3% of these individuals would use social setting detoxification services.
- 66.7% of these individuals would use non-hospital medical detoxification services.
- 10% of individuals needing non-hospital detoxification services are eligible for Medicaid.
- The average cost per day for non-hospital medical detoxification services is $315.
- The cost per day of detoxification services will not inflate over the next five years.
- The average length of stay is 5 days.
- The increase in new detoxification beds will equal the unmet need for services.

Using these assumptions, DHHS calculated the following:

Projected Fiscal Impact (DMA Budget):	**Non-Hospital Medical Detox**
Projected Number of **Medicaid Eligible** Clients to be Served per Year (10% of 2,401 individuals)	240
Cost per Day	$315
Average Number of Days	5
Projected Increased Medicaid Expenditure per Year	**$378,000**
Federal Share @ 62.56%	$236,477
State Share @ 85% of Non-federal	$120,295
County Share @ 15% of Non-federal	$ 21,228

Alcohol and Drug Abuse Treatment Centers (ADATC's)

DHHS is currently developing detoxification service capacity in the State's ADATC's. Without certificate of need requirements for freestanding detoxification activities, the increased capacity for detoxification services across the State could reduce the demand for detoxification beds in the ADATC's.

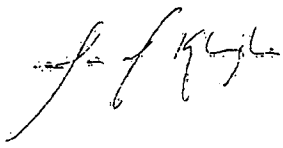
DHHS anticipates that the ADATC detoxification beds will operate at capacity, serving roughly 3.600 persons per year. *These 3,600 persons are not included in the assumption mentioned in the previous section regarding persons with unmet detoxification needs.* According to DHHS,

the 3,600 persons to be served in the ADATC's will be served within existing budget for DHHS. All other impacts addressed in this fiscal note assume that there is an unmet need for detoxification services over and above services provided at the ADATC's. This new detoxification capacity at the ADACT's is not expected to impact the assumed demand for new community detoxification services. **As a result, no net fiscal impact is expected in the DHHS regarding the statewide increase in detoxification beds.**

Division of Facility Services (DFS)
DFS is current responsible for issuing certificates of need to freestanding detoxification facilities. By excluding freestanding detoxification facilities from certificates of need requirements, DFS is expecting a small cost savings associated with reduced workload in issuing certificates of need. This cost savings is balanced by increased costs associated with licensing and regulating an increased number of freestanding detoxification facilities. According to DHHS, the savings and costs should balance out in the end. **As a result, no net fiscal impact is expected to DFS.**

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Jim Klingler, Fiscal Analyst



APPROVED BY: James D. Johnson, Director Fiscal Research Division

DATE: April 23, 2003

VISITOR REGISTRATION SHEET

Senate Health and Human Services Committee — **June 18, 2003**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cleon M. Donald	Rowan Vocational Opportunities Salisbury, NC
Shawn Doorly	Sen. Forester
Julie Allen	NC Statewatch
[signature]	Poyner & Spruill
Karina Chapman	PPHS intern
Peggy Mayhue	[signature]
Hubert Tilson	NCHA
B.J. McMillan	ADCNC - Durham
DENNIS H PARNELL	THE HEALING PLACE OF WAKE COUNTY
Don Willis	DMHDDSAS
[signature]	NCDHHS

VISITOR REGISTRATION SHEET

Senate Health and Human Services Committee — **June 18, 2003**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tony McIntosh	ABCNC
Doug Baker	DMH/DD/SAS
Richard E. Clark	Richard E. Clark & Associates
Stacia McKinney	NC DHHS
Kevin Leonard	WCSR

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 25, 2003 at 11:30 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- **SB 672, Strengthen Public Health Infrastructure, Sen. Hartsell**

III. Other Business

IV. Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 25, 2003
11:30 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:30 A.M. on Wednesday, June 25, 2003 in Room 544 of the Legislative Office Building. Six members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Purcell introduced Senator Hartsell to present his bill, *Strengthen Public Health Infrastructure* to the committee. As the proposed committee substitute had not been sent to the committee members before the meeting, Senator Forrester moved that the rules be suspended and the committee substitute accepted for discussion. Senator Hartsell pointed out that while this bill had been discussed in this committee previously, it was held for discussion with the Department of Health and Human Services. Senator Kinnaird expressed concern about regionalism; Senator Hartsell said that in some instances this would occur. He said that there had been a meeting last week with about 52 local health directors attending. Of these, 50 voted in favor of this bill. Ed Regan of the Association of County Commissioners said that his group could not support the bill at this time and that it was felt that it should have further study as regards its implications. Senator Hartsell replied that many of the implications had been considered and that he felt that the bill should go forward at this time. Senator Kinnaird that Section 4 seems to address the problems brought up by Mr. Regan. Deborah Rowe, Executive Director of the National Association of Public Health Directors, said that with all the changes made, the Association endorses the bill. Ms. Leah Devlin, State Health Director, said that the Division of Public Health supports the bill also. Senator Forrester moved that the proposed committee substitute be passed, with a referral to the Appropriations Committee. The motion carried.

The meeting adjourned at 11:55 A.M.

William R. Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Friday, June 27, 2003

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2

S.B.(CS #1) **672** Strengthen Public Health Infrastructure.

Draft Number:	PCS35333
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 672

Short Title:	Strengthen Public Health Infrastructure.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Health & Human Resources.	

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT OF STATE AND LOCAL COMPREHENSIVE PUBLIC HEALTH PLANS, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE BY ENHANCING COLLABORATION WITH PUBLIC AND PRIVATE SECTOR ENTITIES AND IMPOSING PERFORMANCE STANDARDS FOR PUBLIC HEALTH PRACTICE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure;

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions;

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies, the collaboration of the public and private sectors within the public health system, and the consolidation of local public health agencies;

Whereas, a consensus for establishing, prioritizing and implementing essential public health services and functions can be achieved through locally developed and coordinated health plans that provide the foundation for a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 is repealed.

SECTION 2. G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-1.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6aa) "Local public health agency" means a local health director, a local board of health, and a local health department.

(6a) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency and are identified in the local public health plans in accordance with G.S. 130A-2.7.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, tribal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(8b) "Tribe" means the same as the term 'Indian Tribe' in 25 U.S.C. § 450b(e), section 4(e) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

(8c) "Tribal public health agency" means any program or organization operated by a tribe or tribal organization, including boards, agencies, commissions, or offices, that principally acts or is responsible to protect or preserve the public's health and shall include the health programs of any tribal organization that carries out essential public health services and functions or otherwise acts to protect or preserve the public health.

(8d) "Tribal organization" means the same as the term in 25 U.S.C. § 450b(l), section 4(l) of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 3. Part 1 of Article 1 of Chapter 130A is amended by adding the following new sections to read:

"**§ 130A-2.1. Mission statement.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The mission of the State and local public health agencies is to provide leadership and protect and promote the public's health by:

(1) Providing essential public health services and functions as provided in G.S. 130A-1.3.

(2) Encouraging collaboration among public and private sector partners in the public health system.

(3) Seeking adequate funding to provide essential public health services and functions and to accomplish public health goals from public or private sources.

(c) Nothing in this section shall be construed to require the State or local public health agencies or an individual or agency within the public health system to provide specific health services or to implement unfunded programs.

"**§ 130A-2.2. Responsibilities of State and local governments; private sector collaboration.**

(a) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(b) State and local public health agencies shall collaborate with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-33-55.

(d) State or local public health agencies may contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through these private sector entities if:

(1) The contractor has the potential to improve public health outcomes without causing harm to individuals or the public health system.

(2) Privatized services are fully and regularly monitored by the contracting public health agency or others within the public health system. Nothing is this subdivision shall be construed to require private sector entities to be monitored by other public agencies providing services within the public health system. The State public health agency shall devise, in consultation with others within the public health system, evaluation criteria to be used in conducting performance reviews of any private sector partner that provides privatized services or functions.

(3) Privatized services or functions are subject to other federal, State, or local laws.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies, in collaboration with public and private sector partners, shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Diagnose and investigate health problems and health hazards in the community.

(3) Inform people about health issues.

(4) Develop policies and plans that support individual and community health efforts.

(5) Enforce laws and regulations that protect health and ensure safety.

(6) Link individuals to needed personal health services and facilitate the provision of health care when not otherwise available.

(7) Monitor and ensure the competency of the public health workforce.

(8) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(9) Conduct research to identify new insights and innovative solutions to health problems.

(10) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(11) When not otherwise available through the private sector, collaborate with other public sector partners to promote the availability of and access to preventive and primary health care, including acute and episodic care, prenatal and postpartum care, child health, family

planning, school health, chronic disease preventions, child and adult immunization, dental health, nutrition, and health education and promotion services.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, or the Department of Environment and Natural Resources as otherwise conferred by State law.

"**§ 130A-2.4. Public health infrastructure.**

(a) The Secretary shall coordinate State and local public health agencies and their public and private sector partners to do the following to strengthen and maintain stability of the public health infrastructure:

(1) Identify and provide leadership for the provision of essential public health services and functions;

(2) Develop management standards for the public health system and workforce that are tied to improvements in public health outcomes or other measures;

(3) Develop and provide effective training for members of the public health workforce that is focused on performance-based standards;

(4) Evaluate performance management standards and training efforts within the public health system; and

(5) Comprehensively plan and set priorities for the efficient and effective accomplishment of essential public health services and functions.

(b) In performing the duties set forth in subsection (a) of this section, State and local public health agencies and their public and private sector partners shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

"**§ 130A-2.5. Public health workforce.**

(a) The State public health agency shall manage the public health workforce performance related to public health infrastructure and capacity, processes, and outcomes at the State and local levels. The State public health agency shall establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These include the following:

(1) Performance measurement standards for the public health system. – Consistent with the National Public Health Performance Standards Program, the State public health agency shall adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(2) Accreditation of local public health agencies. – The State public health agency shall adopt and administer a mandatory accreditation program for local public health agencies. The accreditation program shall be based on criteria developed by the State public health agency that

focus on the ability of agencies to provide essential public health services and functions.

(3) Certification or credentialing for the public health workforce. – Consistent with any national system of public health workforce certification or credentialing, the State public health agency shall adopt and administer public health workforce certification or credentialing programs for members of the public health workforce. These programs shall be designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas and must be based on:

a. Basic, core, or technical competencies for public health workers; or

b. Professional codes for public health professionals.

(b) The State public health agency shall, directly or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

(c) The State public health agency may require individuals within the public health system to meet minimal training requirements to assist the individual in providing essential public health services and functions.

(d) The State public health agency may provide incentives to meet performance management or training requirements, including:

(1) Organizational accountability awards.

(2) Accreditation recognition for public health agencies or their contractors or volunteers.

(3) Certification or credentialing titles or recognition for individuals.

(4) Other career development initiatives, including financial benefits.

(e) The State public health agency shall:

(1) Adopt a framework for the evaluation of the performance of the local public health agency workforce.

(2) Develop standards to consistently evaluate the effectiveness and delivery of training programs, continuation education, and other tools.

(3) Consistently evaluate performance management and training programs, continuing education, and other tools pursuant to these frameworks or standards.

"**§ 130A-2.6. Comprehensive public health plan.**

(a) The State public health agency shall develop a comprehensive public health plan ("Plan") that assesses and sets priorities for the State public health system. The State public health agency shall develop the Plan in consultation with representatives from its public and private sector partners and in consideration of local public health plans submitted in accordance with G.S. 130A-2.7. The Plan may rely on existing or available surveillance data or other formation available to the State public health agency, as well as national guidelines or recommendations concerning public health outcomes and improvements. The Plan shall cover five years and shall be reviewed

annually. Future Plans shall be developed every five years. The Plan shall include the following:

(1) Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

(2) Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

(3) Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

(4) Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

(5) Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies and schedules for meeting these goals.

(6) Strategies for coordinating service delivery within the public health system.

(7) Measurable indicators of effectiveness and success.

(8) Identification of public and private sector partners.

(b) The State public health agency shall submit a copy of the comprehensive State public health plan required under this section annually to the Governor and the General Assembly upon its convening or reconvening, including any recommendations for legislative amendments.

"**§ 130A-2.7. Local public health plans.**

(a) Every county, through its local public health agency, shall provide for the development, review, and approval of a local public health plan consistent with the comprehensive State public health plan required under G.S. 130A-5.4. The local public health plan shall address how the local public health agency will coordinate with the State public health agency and others within the public health system to accomplish goal and priorities identified in the comprehensive State public health plan. The local public health plan shall cover five years and shall be reviewed annually. Future plans shall be developed every five years. In addition to the items listed in G.S. 130A-5.4, the local public health plan shall include the following:

(1) Description of the demographics and health indicators of the population being served by the local public health agency.

(2) Description of the numbers and types of professionals in the local public health workforce.

(3) Description of the local public health workforce training needs.

(4) Description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) Description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and are of the highest quality possible.

(6) Description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) Other matters determined by the Secretary to be necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

(b) The local public health plan shall be approved and submitted to the Secretary no later than July 1, 2004.

(c) The State public health agency shall provide technical assistance to local public health agencies that request assistance and shall otherwise work with local public health agencies to generate the plan."

SECTION 4. G.S. 130A-5 reads as rewritten:

"**§ 130A-5. Duties of the Secretary.**

The Secretary shall have the authority:

(1) To enforce the State health laws and the rules of the Commission;

(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish;

(3) To develop and carry out ~~reasonable health programs that may be necessary for the protection and promotion of the public health and the control of diseases.~~ the comprehensive State public health plan pursuant to G.S. 130A-33-58. The Commission is authorized to adopt rules to carry out ~~these programs.~~ the Plan.

(4) To make sanitary and health investigations and inspections;

(5) To investigate occupational health hazards and occupational diseases and to make recommendations for the elimination of the hazards and diseases. The Secretary shall work with the Industrial Commission and shall file sufficient reports with the Industrial Commission to enable it to carry out all of the provisions of the Workers' Compensation Act with respect to occupational disease.

(6) To receive donations of money, securities, equipment, supplies, realty or any other property of any kind or description which shall be used by the Department for the purpose of carrying out its public health programs;

(7) To acquire by purchase, devise or otherwise in the name of the Department equipment, supplies and other property, real or personal, necessary to carry out the public health programs;

(8) To use the official seal of the Department. Copies of documents in the possession of the Department may be authenticated with the seal of the Department, attested by the signature or a facsimile of the signature of the Secretary, and when authenticated shall have the same evidentiary value as the originals;

(9) To disseminate information to the general public on all matters pertaining to public health; to purchase, print, publish, and distribute free, or at cost, documents, reports, bulletins and health informational materials. Money collected from the distribution of these materials shall remain in the Department to be used to replace the materials;

(10) To be the health advisor of the State and to advise State officials in regard to the location, sanitary construction and health management of all State institutions; to direct the attention of the State to health matters which affect the industries, property, health and lives of the people of the State; to inspect at least annually State institutions and facilities; to make a report as to the health conditions of these institutions or facilities with suggestions and recommendations to the appropriate State agencies. It shall be the duty of the persons in immediate charge of these institutions or facilities to furnish all assistance necessary for a thorough inspection;

(11) To establish a schedule of fees based on income to be paid by a recipient for services provided by Migrant Health Clinics and Development Evaluation Centers;

(12) To establish fees for the sale of specimen containers, vaccines and other biologicals. The fees shall not exceed the actual cost of such items, plus transportation costs;

(13) To establish a fee to cover costs of responding to requests by employers for industrial hygiene consultation services and occupational consultation services. The fee shall not exceed two hundred dollars ($200.00) per on site inspection; ~~and~~

(14) To establish a fee for companion animal certificate of examination forms to be distributed, upon request, by the Department to licensed veterinarians. The fee shall not exceed the cost of the form and shipping ~~costs.~~costs;

(15) Conduct performance management and training programs and evaluations to improve the public health system and workforce; and

(16) Systematically review, on at least an annual basis, the public health system to recommend modifications in its structure or other features to improve public health outcomes."

SECTION 5. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the comprehensive State public health plan and the local public health plans:

(1) Develop the State comprehensive public health plan in accordance with G.S. 130A-5.2 not later than January 1, 2005.

(2) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary and identify rules that are inconsistent with this act.

(3) Review all oversight and monitoring functions currently implemented by the Department with respect to the public health system to determine the effectiveness of the activities on achieving the intent of the act; and improve the oversight and monitoring functions and activities, if necessary; identify areas where additional training is needed and provide it.

(4) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(5) Develop format and required content for local public health plans.

(6) Develop a method for Departmental evaluation of local public health plans.

(7) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health plans.

(8) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement public health infrastructure reform no later than October 1, 2003.

(9) Develop a consolidation plan that will result in no less than 10 and no more than 20 local public health agencies by January 1, 2005.

SECTION 6. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one million dollars ($1,000,000) for the 2003-2004 fiscal year. These funds shall be used to create incentives for counties to consolidate public health services into multicounty district health departments.

SECTION 7. Section 6 of this act becomes effective July 1, 2003. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 672

Health & Human Resources Committee Substitute Adopted 6/5/03

PROPOSED COMMITTEE SUBSTITUTE S672-PCS35333-LN-29

Short Title: Strengthen Public Health Infrastructure. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT AND IMPLEMENTATION OF A STATE PLAN FOR PUBLIC HEALTH SERVICES, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure; and

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions; and

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies and the collaboration of the public and private sectors within the public health system; and

Whereas, a consensus for establishing, prioritizing, and implementing essential public health services and functions can be achieved through a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 130A-1.1 is repealed.

SECTION 1.(b) G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-2.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6a) "Local public health agency" means a local health director, a local board of health, and a local health department.

~~(6a)~~(6b) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual

efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 1.(c) Part 1 of Article 1 of Chapter 130A of the General Statutes is amended by adding the following new sections to read:

"**§ 130A-2.1. Policy statement; responsibilities of State and local government.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(c) State and local public health agencies shall encourage collaboration with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-2.3.

"**§ 130A-2.2. Accreditation of State and local public health agencies.**

(a) Not later than January 1, 2005, all local public health agencies shall be accredited. Accreditation shall be conditioned upon the local public health agency's capacity to provide all essential public health services and functions listed in G.S. 130A-2.3 in a manner that promotes quality of services and financial sustainability.

(b) The State public health agency shall obtain an accreditation directed at the duties and functions of a state-level public health agency from a national accrediting body.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Mobilize public and private sector collaboration and action to identify and solve health problems.

(3) Diagnose and investigate health problems and health hazards in the community.

(4) Inform people about health issues.

(5) Develop policies and plans that support individual and community health efforts.

(6) Enforce laws and regulations that protect health and ensure a safe and healthful environment.

(7) Promote access to and availability of needed personal health care services and collaborate with other public and private sector partners to promote or provide preventative and primary health care services according to identified community needs. For the purposes of this subdivision, preventative and primary health care services include acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and

adult immunization, dental health, nutrition, and health education and promotion services.

(8) Monitor and ensure the competency of the State and local public health workforce.

(9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(10) Conduct research to identify new insights and innovative solutions to health problems.

(11) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(12) Establish and maintain an effective public health preparedness and response capacity for all hazards.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, rules adopted by local boards of health, or the Department of Environment and Natural Resources as otherwise conferred by State law."

SECTION 2.(a) Every county, through its local public health agency, shall develop local priorities for public health. These priorities shall be the basis for development of a State Plan for Public Health Services. To ensure the involvement of consumers and providers and other interested parties in the development of priorities the local board of health and board of county commissioners shall hold a public hearing with notice published at least 10 days prior to the hearing. The priorities shall include the following:

(1) A description of the demographics and health indicators of the population being served by the local public health agency.

(2) A description of the numbers and types of professionals in the local public health workforce.

(3) A description of the local public health workforce training needs.

(4) A description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) A description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and of the highest quality possible.

(6) A description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) A description of how the local public health agency will coordinate with the State public health agency and others within the local public health system to accomplish identified priorities.

(9) Other matters necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

At the request of a county, the State public health agency shall provide technical assistance to the county in developing the priorities required under this subsection. Every county shall submit its priorities to the Secretary of Health and Human Services not later than January 1, 2004.

SECTION 2.(b) Part 1 of Article 1 of Chapter 130A of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new section to read:

"**§ 130A-2.4. State Plan for Public Health Services.**

(a) The Secretary shall develop and implement a State Plan for Public Health Services. The State Plan shall cover five years and shall be reviewed annually in consultation with the planning committee. Future plans shall be developed every five years. The State Plan shall address the following:

(1) The vision and mission of the State Public Health System.

(2) Strategies for strengthening and maintaining stability of the public health infrastructure, including the following:

a. Comprehensive planning and setting of priorities for the efficient and effective accomplishment of essential public health services and functions.

b. Management standards for the State and local public health workforce that are tied to improvements in public health outcomes or other measures.

In developing strategies under this subdivision, the Secretary shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

(3) Strategies for strengthening the competencies of the State and local public health workforce, including performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These strategies shall include all of the following:

a. Certification or credentialing programs that are consistent with any approved and recognized system of public health workforce certification or credentialing and that are designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas.

1. Basic, core, or technical competencies for public health workers;

2. Professional codes for public health professionals.

b. Continuing education or other tools for ongoing training of public health practitioners within the public health system.

c. Minimal training requirements for individuals that provide essential public health services.

d. Incentives to meet performance management or training requirements, including:
1. Organizational accountability awards.
2. Accreditation recognition for public health agencies or their contractors or volunteers.
3. Certification or credentialing titles or recognition for individuals.
4. Other career development initiatives, including financial benefits.

e. A framework for the evaluation of the performance of the State and local public health agency workforce.

f. Standards to evaluate the effectiveness and delivery of training programs, continuing education, and other tools.

(4) Priorities and goals for the State Public Health System concerning public health outcomes and improvements. These priorities and goals shall reflect local public health agency priorities and goals and shall include the following:

a. Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

b. Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

c. Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

d. Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

e. Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies, and schedules for meeting these goals.

f. Strategies for coordinating service delivery within the public health system.

g. Measurable indicators of effectiveness and success.

h. Identification of public and private sector partners.

(5) A plan to identify resources to provide adequate funding to provide essential public health services and functions.

(6) An organizational plan for the effective integration and monitoring of public health and environmental health services.

(7) Provide a framework for local public health planning.

(b) The Secretary shall develop the plan in consultation with the planning committee appointed by the Secretary.

SECTION 2.(c) The Secretary of Health and Human Services shall appoint a planning committee to assist in the development of the State Plan for Public Health Services required by this act. The planning committee shall include representatives of the Division of Public Health, the Division of Medical Assistance, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the Department of Health and Human Services, local health departments (including district health departments and rural and urban area health departments), boards of county commissioners, local boards of health, and consumers, appointed by the Secretary. The planning committee shall also include four members of the General Assembly, two appointed by the President Pro Tempore of the Senate, and two appointed by the Speaker of the House of Representatives. The Secretary shall appoint the chair of the planning committee. The Secretary shall provide to the Committee the priorities submitted by local public health agencies for consideration in the development of the State Plan for Public Health Services. The Secretary shall report to the Joint Legislative Health Care Oversight Committee on or before May 1, 2004, on the status of the State Plan for Public Health Services. The Secretary shall adopt a final plan no later than October 1, 2004.

SECTION 3.(a) The lead sentence of G.S. 130A-5 reads as rewritten:

"**§ 130A-5. Duties of the Secretary.**

...

"(a) The Secretary shall have the authority:"

SECTION 3.(b) G.S. 130A-5, as amended by subsection (a) of this section, is amended by adding the following new subsection to read:

"(b) The Secretary shall do the following:

(1) Identify and provide leadership for the provision of essential public health services and functions.

(2) Develop and provide effective training for members of the State and local public health workforce that is focused on performance-based standards.

(3) Evaluate performance management standards and training efforts within State and local public health agencies.

(4) Adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(5) Adopt and administer State and local public health workforce certification or credentialing programs for members of public health agencies."

SECTION 4. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the State Plan for Public Health Services:

(1) Ensure that local public health priorities required under Section 2(a) of this act are submitted no later than January 1, 2004.

(2) In consultation with local public health agencies, the State public health agency shall adopt and administer an accreditation program.

The accreditation program shall be uniformly applied to all local health agencies. The State public health agency shall provide technical assistance upon request to assist local health agencies obtain accreditation.

(3) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary of Health and Human Services and identify rules that are inconsistent with this act.

(4) Review all oversight and monitoring functions currently implemented for public health, including environmental health, with respect to the public health system to determine the effectiveness of the activities on achieving the intent of this act; improve the oversight and monitoring functions and activities, if necessary; and identify areas where additional training is needed and provide it; make recommendations for an organizational plan to improve effectiveness in the provision of public health and environmental health services consistent with this act.

(5) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(6) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health priorities.

(7) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement the State Plan for Public Health Services no later than May 1, 2004.

SECTION 5. The Secretary may utilize new or existing resources during fiscal year 2003-2004 to initiate the implementation of this act.

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 672

Health & Human Resources Committee Substitute Adopted 6/5/03
PROPOSED COMMITTEE SUBSTITUTE S672-CSLN-29 [v.10]

6/25/2003 10:17:21 AM

Short Title: Strengthen Public Health Infrastructure. (Public)

Sponsors:

Referred to:

April 2, 2003

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE QUALITY AND ACCOUNTABILITY OF THE PUBLIC HEALTH SYSTEM BY STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE, TO IMPROVE PUBLIC HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES BY THE DEVELOPMENT AND IMPLEMENTATION OF A STATE PLAN FOR PUBLIC HEALTH SERVICES, AND TO IMPROVE THE PUBLIC HEALTH WORKFORCE.

Whereas, North Carolina has a rich local public health heritage and wishes to continue that heritage by strengthening the State's public health infrastructure; and

Whereas, the public health system must respond to: new serious public health emergencies, significant changes in population, decreasing funding, and significant variations in public health protection between counties and regions; and

Whereas, the mission of protecting and promoting the health of the public can most efficiently and effectively be addressed through the coordinated efforts of State and local public health agencies and the collaboration of the public and private sectors within the public health system; and

Whereas, a consensus for establishing, prioritizing, and implementing essential public health services and functions can be achieved through a comprehensive statewide public health plan; and

Whereas, the public and private sectors can demonstrate public accountability and provide high quality services through accreditation, certification, credentialing, and the implementation of performance standards; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 130A-1.1 is repealed.

SECTION 1.(b) G.S. 130A-2 reads as rewritten:

"**§ 130A-2. Definitions.**

The following definitions shall apply throughout this Chapter unless otherwise specified:

(1) "Commission" means the Commission for Health Services.

(1a) "Communicable condition" means the state of being infected with a communicable agent but without symptoms.

(1b) "Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

(2) "Department" means the Department of Health and Human Services.

(2a) "Essential public health services and functions" means those services and functions listed in G.S. 130A-2.3.

(3) "Imminent hazard" means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.

(3a) "Isolation authority" means the authority to issue an order to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

(4) "Local board of health" means a district board of health or a public health authority board or a county board of health.

(5) "Local health department" means a district health department or a public health authority or a county health department.

(6) "Local health director" means the administrative head of a local health department appointed pursuant to this Chapter.

(6a) "Local public health agency" means a local health director, a local board of health, and a local health department.

~~(6a)~~(6b) "Outbreak" means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

(7) "Person" means an individual, corporation, company, association, partnership, unit of local government or other legal entity.

(7a) "Private sector partner" means nongovernmental persons, including community organizations, contractors, educational institutions, health care facilities, health insurers, private businesses, media, nonprofit organizations, and volunteers, that provide essential public health services and functions or work to improve public health outcomes in collaboration with the State or a local public health agency.

(7b) "Public health" means assuring the conditions in which the population can be healthy. The term includes population-based or individual

efforts primarily aimed at the prevention of injury, disease, or premature mortality or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(7c) "Public health agency" means a federal, State, or local public health agency.

(7d) "Public health infrastructure" means the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the State.

(7e) "Public health system" means State and local public health agencies and their public and private sector partners.

(7f) "Public health workforce" means State and local public health agents and other persons working within the public health system to provide essential public health services and functions in the State.

(7g) "Public sector partner" means international, federal, tribal, or other State or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a State or local public health agency.

~~(7a)~~(7h) "Quarantine authority" means the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. Quarantine authority also means the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent. The term also means the authority to issue an order to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease when the State Health Director or a local health director determines that the immunizations are required to control an outbreak of that disease.

(8) "Secretary" means the Secretary of Health and Human Services.

(8a) "State public health agency" means the Commission for Health Services, the Department of Health and Human Services, and the Department of Environment and Natural Resources to the extent that the Department of Environment and Natural Resources has jurisdiction to protect the public's health.

(9) "Unit of local government" means a county, city, consolidated city-county, sanitary district or other local political subdivision, authority or agency of local government.

(10) "Vital records" means birth, death, fetal death, marriage, annulment and divorce records registered under the provisions of Article 4 of this Chapter."

SECTION 1.(c) Part 1 of Article 1 of Chapter 130A of the General Statutes is amended by adding the following new sections to read:

"**§ 130A-2.1. Policy statement; responsibilities of State and local government.**

(a) The policy of the State is to protect and promote the health of the public to the greatest extent possible through the public health system while respecting individual rights to bodily integrity, health information privacy, nondiscrimination, due process, and other legally protected interests.

(b) The State and counties are responsible for assuring that the public health system accomplishes the mission of public health.

(c) State and local public health agencies shall encourage collaboration with public and private sector partners within the public health system to provide essential public health services and functions listed in G.S. 130A-2.3.

"**§ 130A-2.2. Accreditation of State and local public health agencies.**

(a) Not later than January 1, 2005, all local public health agencies shall be accredited. Accreditation shall be conditioned upon the local public health agency's capacity to provide all essential public health services and functions listed in G.S. 130A-2.3 in a manner that promotes quality of services and financial sustainability.

(b) The State public health agency shall obtain an accreditation directed at the duties and functions of a state-level public health agency from a national accrediting body.

"**§ 130A-2.3. Essential public health services and functions.**

(a) State and local public health agencies shall provide the following essential public health services and functions:

(1) Monitor health status to identify and solve community health problems.

(2) Mobilize public and private sector collaboration and action to identify and solve health problems.

(3) Diagnose and investigate health problems and health hazards in the community.

(4) Inform people about health issues.

(5) Develop policies and plans that support individual and community health efforts.

(6) Enforce laws and regulations that protect health and ensure a safe and healthful environment.

(7) Promote access to and availability of needed personal health care services and collaborate with other public and private sector partners to promote or provide preventative and primary health care services according to identified community needs. For the purposes of this subdivision, preventative and primary health care services include acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and

adult immunization, dental health, nutrition, and health education and promotion services.

(8) Monitor and ensure the competency of the State and local public health workforce.

(9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

(10) Conduct research to identify new insights and innovative solutions to health problems.

(11) Promote the availability and accessibility of quality health care services through health care facilities or providers.

(12) Establish and maintain an effective public health preparedness and response capacity for all hazards.

(b) The essential public health services and functions listed in subsection (a) of this section shall not be construed to limit or restrict the powers and duties of the Commission, the Department, rules adopted by local boards of health, or the Department of Environment and Natural Resources as otherwise conferred by State law.

SECTION 2.(a) Every county, through its local public health agency, shall develop local priorities for public health. These priorities shall be the basis for development of a State Plan for Public Health Services. To ensure the involvement of consumers and providers and other interested parties in the development of priorities the local board of health and board of county commissioners shall hold a public hearing with notice published at least 10 days prior to the hearing. The priorities shall include the following:

(1) A description of the demographics and health indicators of the population being served by the local public health agency.

(2) A description of the numbers and types of professionals in the local public health workforce.

(3) A description of the local public health workforce training needs.

(4) A description of how the local public health agency is accountable to the public in ensuring the provision of essential public health services and functions.

(5) A description of how the local public health agency provides the necessary leadership to ensure that public health services are managed, monitored, and of the highest quality possible.

(6) A description of how the local public health agency manages its finances and accounts for expenditures of State, local, and all other sources of revenue.

(7) Identification of public and private sector partners.

(8) A description of how the local public health agency will coordinate with the State public health agency and others within the local public health system to accomplish identified priorities.

(9) Other matters necessary to effectively and efficiently provide essential public health services and functions by a local public health agency.

At the request of a county, the State public health agency shall provide technical assistance to the county in developing the priorities required under this subsection. Every county shall submit its priorities to the Secretary of Health and Human Services not later than January 1, 2004.

SECTION 2.(b) Part 1 of Article 1 of Chapter 130A of the General Statutes, as amended by Section 1.(c) of this act, is amended by adding the following new section to read:

"**§ 130A-2.4. State Plan for Public Health Services.**

(a) The Secretary shall develop and implement a State Plan for Public Health Services. The State Plan shall cover five years and shall be reviewed annually in consultation with the planning committee. Future plans shall be developed every five years. The State Plan shall address the following:

(1) The vision and mission of the State Public Health System.

(2) Strategies for strengthening and maintaining stability of the public health infrastructure, including the following:

a. Comprehensive planning and setting of priorities for the efficient and effective accomplishment of essential public health services and functions.

b. Management standards for the State and local public health workforce that are tied to improvements in public health outcomes or other measures.

In developing strategies under this subdivision, the Secretary shall consult with and utilize national guidelines, initiatives, programs, and recommendations relating to improvements in public health infrastructure that are consistent with accomplishing the mission of public health in the State.

(3) Strategies for strengthening the competencies of the State and local public health workforce, including performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. These strategies shall include all of the following:

a. Certification or credentialing programs that are consistent with any approved and recognized system of public health workforce certification or credentialing and are designed to develop knowledge, skills, and abilities in relevant and contemporary public health practice areas.

(i.) Basic, core, or technical competencies for public health workers;

(ii.) Professional codes for public health professionals.

b. Continuing education or other tools for ongoing training of public health practitioners within the public health system.

c. Minimal training requirements for individuals that provide essential public health services.

d. Incentives to meet performance management or training requirements, including:
1. Organizational accountability awards.
2. Accreditation recognition for public health agencies or their contractors or volunteers.
3. Certification or credentialing titles or recognition for individuals.
4. Other career development initiatives, including financial benefits.

e. A framework for the evaluation of the performance of the State and local public health agency workforce.

f. Standards to evaluate the effectiveness and delivery of training programs, continuing education, and other tools.

(4) Priorities and goals for the State Public Health System concerning public health outcomes and improvements. These priorities and goals shall reflect local public health agency priorities and goals and shall include the following:

a. Identification and quantification of existing public health problems, disparities, or threats at the State and local levels.

b. Identification of areas needing greater resource allocation to effectively combat public health threats or decrease disparities in the provision of essential public health services and functions.

c. Goals for targeting essential public health services and functions to address prioritized public health problems, disparities, or threats through program development, implementation, and evaluation and specific recommendations, strategies, and schedules for meeting these goals.

d. Identification of specific at-risk populations targeted, including criteria for identifying targeted populations.

e. Goals for increasing the efficiency and effectiveness of the public health system and specific recommendations, strategies, and schedules for meeting these goals.

f. Strategies for coordinating service delivery within the public health system.

g. Measurable indicators of effectiveness and success.

h. Identification of public and private sector partners.

(5) A plan to identify resources to provide adequate funding to provide essential public health services and functions.

(6) An organizational plan for the effective integration and monitoring of public health and environmental health services.

(7) Provide a framework for local public health planning.

(b) The Secretary shall develop the plan in consultation with the planning committee appointed by the Secretary.

SECTION 2.(c) The Secretary of Health and Human Services shall appoint a planning committee to assist in the development of the State Plan for Public Health Services required by this act. The planning committee shall include representatives of the Division of Public Health, the Division of Medical Assistance, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the Department of Health and Human Services, local health departments (including district health departments and rural and urban area health departments), boards of county commissioners, local boards of health, and consumers, appointed by the Secretary. The planning committee shall also include four members of the General Assembly, two appointed by the President Pro Tempore of the Senate, and two appointed by the Speaker of the House of Representatives. The Secretary shall appoint the chair of the planning committee. The Secretary shall provide to the Committee the priorities submitted by local public health agencies for consideration in the development of the State Plan for Public Health Services. The Secretary shall report to the Joint Legislative Health Care Oversight Committee on or before May 1, 2004 on the status of the State Plan for Public Health Services. The Secretary shall adopt a final plan no later than October 1, 2004.

SECTION 3.(a) The lead sentence of G.S. 130A-5 reads as rewritten:

"§ 130A-5. Duties of the Secretary.

...

"(a) The Secretary shall have the authority:"

SECTION 3.(b) G.S. 130A-5, as amended by subsection (a) of this section, is amended by adding the following new subsection to read:

"(b) The Secretary shall do the following:

(1) Identify and provide leadership for the provision of essential public health services and functions.

(2) Develop and provide effective training for members of the State and local public health workforce that is focused on performance-based standards.

(3) Evaluate performance management standards and training efforts within State and local public health agencies.

(4) Adopt and administer performance measurements within the public health system as a means of improving the quality of State and local public health practice and improving system accountability.

(5) Adopt and administer State and local public health workforce certification or credentialing programs for members of public health agencies."

SECTION 4. The Department of Health and Human Services shall do the following to prepare for the development and implementation of the State Plan for Public Health Services:

(1) Ensure that local public health priorities required under Section 2(a) of this act are submitted no later than January 1, 2004.

(2) In consultation with local public health agencies, the State public health agency shall adopt and administer an accreditation program.

The accreditation program shall be uniformly applied to all local health agencies. The State public health agency shall provide technical assistance upon request to assist local health agencies obtain accreditation.

(3) Review all rules currently in effect and adopted by the Commission for Health Services and the Secretary of Health and Human Services and identify rules that are inconsistent with this act.

(4) Review all oversight and monitoring functions currently implemented for public health, including environmental health, with respect to the public health system to determine the effectiveness of the activities on achieving the intent of this act; improve the oversight and monitoring functions and activities, if necessary; and identify areas where additional training is needed and provide it; make recommendations for an organizational plan to improve effectiveness in the provision of public health and environmental health services consistent with this act.

(5) Develop service standards, outcomes, and financing strategies necessary to implement this act.

(6) Develop contractual agreements for the provision of technical assistance by the Department to local public health agencies in the development of local public health priorities.

(7) Report to the Joint Legislative Health Care Oversight Committee on the Department's readiness to implement the State Plan for Public Health Services no later than May 1, 2004.

SECTION 5. The Secretary may utilize new or existing resources during fiscal year 2003-2004 to initiate the implementation of the Act.

SECTION 6. This act is effective when it becomes law.

SENATE BILL 672:
Strengthen Public Health Infrastructure

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Senator Hartsell
Date:	June 25, 2003	**Summary by:**	Sandra Alley
Version:	S672-CSLN-29[v. 10]		Committee Counsel

SUMMARY: ***SB 672 bill directs the Secretary of Health and Human Services to work with local public health agencies in the development of a State Public Health Plan. It also requires the accreditation of State and local health agencies. It allows the Secretary to use new and existing resources to fund these efforts. This bill becomes effective when it becomes law.***

Bill Analysis Under the New PCS:

Sections 1-3:

- Repeals G.S. 130A-1.1, which described the State mission statement for public health.
- Establishes State policy regarding the public health system and the health of the public;
- Requires accreditation of State and local public health agencies;
- Encourages public health agencies to collaborate with private sector partners;
- Directs the Secretary of Health and Human Resources to develop, with the assistance of a broad based planning group, and implement a State Plan for Public Health Services. The Plan shall be completed and submitted to the General Assembly no later than October 1, 2004.
    a. The Secretary is to appoint a planning committee (See Section 2.(c)) to assist in the development of the Plan.
    b. The Plan must reflect local public health priorities that must be developed through a collaborative process at the local level. (Local input is due no later than January 1, 2004)
    c. The Plan must address:
        - The vision and mission of the State Public Health System.
        - Strategies for strengthening and maintaining stability of the public health infrastructure.
        - Strategies for strengthening the competencies of the public health workforce.
        - Priorities and goals for the State Public Health System.
        - Provide for a plan to identify resources to provide adequate funding to provide essential public health services and functions.
        - Develop an organizational plan for the effective integration and monitoring of public health and environmental health services.
        - Provide a framework for local public health planning.

Section 3:

Requires the Secretary to provide the necessary leadership, training, standards, etc., to implement the components of the State Plan.

Section 4:

Directs the Secretary to make report to the Joint Legislative Health Care Oversight Committee no later than May 1, 2004 on the ability of the Department to implement the State plan.

Section 5:
Allows the Secretary to utilize new and existing resources to initiate implementation of the Act.

Effective date: This bill becomes effective when it becomes law.

CURRENT LAW: Under G.S. 130A-1.1 the mission of the State public health system is to promote and contribute to the highest levels of health possible for the people of North Carolina by: 1) preventing health risks and disease; 2) Identifying and reducing health risks and diseases; 3) Detecting, investigating, and preventing the spread of disease; 4) Promoting health lifestyles; 5) Promoting a safe and healthful environment; 6) Promoting the availability and accessibility of quality health care services through the private sector; and 7) Providing quality health care services when not otherwise available. G.S. 130A-1.1 defines "essential public health services" as those services that the state shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North Carolina. In addition G.S. 130A-1.1 states that the Departments of Environment and Natural Resources and Health and Human Services shall attempt to ensure that certain essential public health services are available and accessible to all citizens of the state and shall account for the financing of these services which include, generally, 1) Health Support; 2) Environmental Health; and 3) Personal Health.

Local public health services are provided by counties (G.S. 130A-33.51). A county may operate a county health department, establish a consolidated human services agency pursuant to G.S. 153A-77 (Mecklenburg and Wake Counties only), participate in district health department, or contract with the state for the provision of health services.

Currently there are 85 public health departments operating in North Carolina.

BACKGROUND:

In the 1990's there was a growing awareness among some public health leaders that significant adjustments were needed in the organization, financing and provision of public health in North Carolina. At least eight major studies were conducted to determine how local public health should adapt to meet the new challenges to protect the public's health.

The studies demonstrated an awareness of the need for change, an ability to bring community leaders together, an ability to focus on solutions rather than problems, and a need to develop action plans. Thus far, no significant actions have taken place as a result of these efforts.

Linda Attarian, former Staff Attorney, Research Division, contributed to this report.

S672-SMLN-001

VISITOR REGISTRATION SHEET

Senate Committee on Health & Human Resources — **June 25, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leah Devlin	DHHS/DPH
Ed Regan	N.C.A.C.C.
Cam Cowell	BPMHL
Angie McMillan	TNC
DAVID BARNES	Poyner + Spruill LLP
John Cyrus	NC State Grange
BILL RUSTIN	ARP
Patricia Ramler	NCACC
Anne Dunn	???
Karina Chapman	PPHS intern
BRIAN LEWIS	Planned Parenthood Health Sys.
Shawn Doorly	Sen. Forrester

VISITOR REGISTRATION SHEET

Senate Committee on Health & Human Resources — June 25, 2003

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Eddie Caldwell	Hafer & Caldwell, P.A.
Jennifer M. Wilson	NASW-NC
Jesse Chisholm	NASW-NC

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Tuesday, July 15, 2003 at 11:00 A.M.
Room 1124, Legislative Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

BILL NO.	SHORT TITLE	SPONSOR
HB 1257	Amend Respiratory Care Practice Act/Fees.	Rep. Nye Rep. Tolson

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Tuesday, July 15, 2003
11:00 A.M.
Room 1124, Legislative Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Tuesday, July 15, 2003 in Room 1124 of the Legislative Building. Eight members were present. Senator Stan Bingham, Co-Chair presided. Senator Bingham and Senator William R. Purcell, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Bingham asked for a motion to wave the rule to consider the Proposed Committee Substitute being heard today. The motion was made by Senator Queen and the motion carried.

Representative Joe Tolson was recognized to explain the bill, HB 1257, ***Amend Respiratory Care Practice Act/Fees*** to the Committee. Two years ago The Respiratory Care Practice Act was passed. The Association in trying to get up and operating and they have asked for some minor changes. The first is in section one, NCHA would be spelled out as North Carolina Hospital Associations. In section two the qualifications for fitness for the license procedures. Also in section three for passing or meeting the requirement of an approved course. They want the course approved by the board. Second page on line two asking for the same thing on basic cardiac life support that it be board approved. They also would like a temporary licensing procedure. They are getting some people coming in from Canada and would like to provide temporary licenses until they can check their credential making sure they are meeting the requirements of NC. Also they are asking for changes in some fees.

Senator Allran asked in regards to the temporary license what will it allow them to do. It will allow them to go to work while they are verifying their credentials. Staff Dianna Jessup stated they can practice for 90 days with a temporary license.

Floyd Boyer, Executive Director of the NC Respiratory Care Board, stated the provisional license is for an individual who has just graduated the Respiratory Therapy Program and allows them one year under direct supervision while they pass the examination required by the licensing board. Temporary is for people who have come into NC and just need verification of their credentials.

After more discussion Senator Dannley made the motion for a favorable report to the Proposed Committee Substitute, unfavorable to the original bill, with a sequential referral to the Finance Committee. The motion carried unanimously.

The meeting adjourned at 11:23.

Senator Stan Bingham

Senator William R. Purcell

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Tuesday, July 15, 2003

SENATOR BINGHAM,
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) **1257** Amend Respiratory Care Practice Act/Fees.

Draft Number:	PCS80352
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 1257
Committee Substitute Favorable 6/16/03

Short Title: Amend Respiratory Care Practice Act/Fees. (Public)

Sponsors:

Referred to:

April 24, 2003

A BILL TO BE ENTITLED

AN ACT AMENDING VARIOUS PROVISIONS UNDER THE RESPIRATORY CARE PRACTICE ACT, AUTHORIZING THE NORTH CAROLINA RESPIRATORY CARE BOARD TO ESTABLISH FEES FOR VERIFICATION OF LICENSURE STATUS AND APPROVAL OF CONTINUING EDUCATION PROGRAMS, AUTHORIZING THE BOARD TO ASSESS CIVIL PENALTIES FOR VIOLATIONS OF THE ACT, AND AUTHORIZING ADJUSTMENTS IN FEES FOR BOARDS TO REFLECT CHANGES IN THE CONSUMER PRICE INDEX.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-652(1) reads as rewritten:

"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. The Board shall, in its discretion, investigate the background of an applicant to determine the applicant's qualifications with due regard given to the applicant's competency, honesty, truthfulness, and integrity."

SECTION 2. G.S. 90-653(a) reads as rewritten:

"(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.~~approved by the Board.

(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.~~Board.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc."

SECTION 3. G.S. 90-654 reads as rewritten:

"**§ 90-654. ~~Exemption from certain requirements.~~Temporary license.**

~~(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.~~

Upon application and payment of the required fees, the Board may grant a temporary license to a person who, at the time of application, submits notarized copies of the items required in G.S. 90-653(a)(3) through (a)(5) while awaiting official copies of the items from the issuing agency. The temporary license shall be valid for a period not to exceed 90 days from the date of application."

SECTION 4. G.S. 90-656 reads as rewritten:

"**§ 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 direct 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."

SECTION 5. G.S. 90-660(b) reads as rewritten:

"(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 two hundred dollars ($200.00).

(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 official verification of licensure status, a fee not to exceed twenty dollars ($20.00).
(8) For approval of continuing education programs, a fee not to exceed one hundred fifty dollars ($150.00).
~~(7)~~(9) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing."

SECTION 6. Article 38 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-666. Civil penalties.**

(a) Authority to Assess Civil Penalties. – In addition to taking any of the actions permitted under G.S. 90-659, the Board may assess a civil penalty not to exceed one thousand dollars ($1,000) for the violation of any section of this Article or any rules adopted by the Board. The clear proceeds of any civil penalty assessed under this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(b) Consideration Factors. – Before imposing and assessing a civil penalty and fixing the amount of the penalty, the Board shall, as a part of its deliberations, consider the following factors:

(1) The nature, gravity, and persistence of the particular violation.
(2) The appropriateness of the imposition of a civil penalty when considered alone or in combination with other punishment.
(3) Whether the violation was willful and malicious.
(4) Any other factors that would tend to mitigate or aggravate the violations found to exist.

(c) Schedule of Civil Penalties. – The Board shall establish a schedule of civil penalties for violations of this Article. The schedule shall indicate for each type of violation whether the violation can be corrected. Penalties shall be assessed for the first, second, and third violations of specified sections of this Article and for specified rules.

(d) Costs. – The Board may, in an action brought under this section or in any other disciplinary proceeding, charge costs, including reasonable attorneys' fees, to the licensee against whom the proceedings were brought."

SECTION 7. Chapter 93B of the General Statutes is amended by adding a new section to read:

"**§ 93B-17. Fees to be consistent with Consumer Price Index; notice.**

(a) When the General Assembly establishes an occupational licensing board, the General Assembly shall set the fees that may be charged by the board to reflect the board's anticipated regulatory and operating costs. New occupational licensing boards and existing occupational licensing boards may increase license fees previously set by the General Assembly by an amount not to exceed the cumulative amount of the percentage increase in the Consumer Price Index (CPI) since the fees were last adjusted. The fee increase may be rounded to the nearest dollar. However, a board shall not set fees by an amount that exceeds its regulatory and operating costs.

(b) Occupational licensing boards shall publish notice of any fee increase in the North Carolina Register and in a newspaper of general circulation not less than 60 days before the fee increase becomes effective. Boards shall notify their current members of any fee increase, by mail, not less than 60 days before the fee increase becomes effective. Each board shall report annually to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division on all fees increased under this section.

(c) This section applies only to the North Carolina Respiratory Care Board."

SECTION 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1257

Committee Substitute Favorable 6/16/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H1257-CSSWf-60 [v.2]

7/9/2003 4:25:57 PM

Short Title: Amend Respiratory Care Practice Act/Fees. (Public)

Sponsors:

Referred to:

April 24, 2003

A BILL TO BE ENTITLED

AN ACT AMENDING VARIOUS PROVISIONS OF THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-649(a)(3) reads as rewritten:

"(3) One member shall represent the ~~NCHA.~~ North Carolina Hospital Association."

SECTION 2. G.S. 90-652(1) reads as rewritten:

"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. The Board shall, in its discretion, investigate the background of an applicant to determine the applicant's qualifications with due regard given to the applicant's competency, honesty, truthfulness, and integrity."

SECTION 3. G.S. 90-653(a) reads as rewritten:

"(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.~~approved by the Board.

(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.~~Board.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc."

SECTION 4. G.S. 90-654 reads as rewritten:

"**§ 90-654. ~~Exemption from certain requirements.~~Temporary license.**

~~(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.~~

Upon application and payment of the required fees, the Board may grant a temporary license to a person who, at the time of application, submits notarized copies of the items required in G.S. 90-653(a)(3) through (a)(5) while awaiting official copies of the items from the issuing agency. The temporary license shall be valid for a period not to exceed 90 days from the date of application."

SECTION 5. G.S. 90-656 reads as rewritten:

"**§ 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 direct 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."

SECTION 6. G.S. 90-660(b) reads as rewritten:

"(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 two hundred dollars ($200.00).

(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.
(8) For official verification of licensure status, a fee not to exceed twenty dollars ($20.00).
(9) For approval of continuing education programs, a fee not to exceed one hundred fifty dollars ($150.00)."

SECTION 7. G.S. 90-661 reads as rewritten:

"**§ 90-661. Requirement of license.**

~~After October 1, 2002, it~~ 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."

SECTION 8. Article 38 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-666. Civil penalties.**

(a) Authority to Assess Civil Penalties. – In addition to taking any of the actions permitted under G.S. 90-659, the Board may assess a civil penalty not to exceed one thousand dollars ($1,000) for the violation of any section of this Article or any rules adopted by the Board. The clear proceeds of any civil penalty assessed under this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(b) Consideration Factors. – Before imposing and assessing a civil penalty and fixing the amount of the penalty, the Board shall, as a part of its deliberations, consider the following factors:

(1) The nature, gravity, and persistence of the particular violation.
(2) The appropriateness of the imposition of a civil penalty when considered alone or in combination with other punishment.
(3) Whether the violation was willful and malicious.

(4) Any other factors that would tend to mitigate or aggravate the violations found to exist.

(c) Schedule of Civil Penalties. – The Board shall establish a schedule of civil penalties for violations of this Article. The schedule shall indicate for each type of violation whether the violation can be corrected. Penalties shall be assessed for the first, second, and third violations of specified sections of this Article and for specified rules.

(d) Costs. – The Board may, in an action brought under this section or in any other disciplinary proceeding, charge costs, including reasonable attorneys' fees, to the licensee against whom the proceedings were brought."

SECTION 9. This act becomes effective December 1, 2003, and applies to civil penalties assessed on or after that date.

SENATE
COMMITTEE SUBSTITUTE
JUL 15 2003
ADOPTED

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 1257
Committee Substitute Favorable 6/16/03
PROPOSED SENATE COMMITTEE SUBSTITUTE H1257-PCS80352-SWf-60

Short Title: Amend Respiratory Care Practice Act/Fees. (Public)

Sponsors:

Referred to:

April 24, 2003

A BILL TO BE ENTITLED

AN ACT AMENDING VARIOUS PROVISIONS OF THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-649(a)(3) reads as rewritten:

"(3) One member shall represent the ~~NCHA.~~ North Carolina Hospital Association."

SECTION 2. G.S. 90-652(1) reads as rewritten:

"(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure. The Board shall, in its discretion, investigate the background of an applicant to determine the applicant's qualifications with due regard given to the applicant's competency, honesty, truthfulness, and integrity."

SECTION 3. G.S. 90-653(a) reads as rewritten:

"(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.~~approved by the Board.

(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.~~Board.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc."

SECTION 4. G.S. 90-654 reads as rewritten:

"**§ 90-654. ~~Exemption from certain requirements.~~Temporary license.**

~~(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.~~

Upon application and payment of the required fees, the Board may grant a temporary license to a person who, at the time of application, submits notarized copies of the items required in G.S. 90-653(a)(3) through (a)(5) while awaiting official copies of the items from the issuing agency. The temporary license shall be valid for a period not to exceed 90 days from the date of application."

SECTION 5. G.S. 90-656 reads as rewritten:

"**§ 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 direct 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."

SECTION 6. G.S. 90-660(b) reads as rewritten:

"(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 two hundred dollars ($200.00).

(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.
(8) For official verification of licensure status, a fee not to exceed twenty dollars ($20.00).
(9) For approval of continuing education programs, a fee not to exceed one hundred fifty dollars ($150.00)."

SECTION 7. G.S. 90-661 reads as rewritten:

"**§ 90-661. Requirement of license.**

~~After October 1, 2002, it~~ 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."

SECTION 8. Article 38 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-666. Civil penalties.**

(a) Authority to Assess Civil Penalties. – In addition to taking any of the actions permitted under G.S. 90-659, the Board may assess a civil penalty not to exceed one thousand dollars ($1,000) for the violation of any section of this Article or any rules adopted by the Board. The clear proceeds of any civil penalty assessed under this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(b) Consideration Factors. – Before imposing and assessing a civil penalty and fixing the amount of the penalty, the Board shall, as a part of its deliberations, consider the following factors:

(1) The nature, gravity, and persistence of the particular violation.
(2) The appropriateness of the imposition of a civil penalty when considered alone or in combination with other punishment.
(3) Whether the violation was willful and malicious.
(4) Any other factors that would tend to mitigate or aggravate the violations found to exist.

(c) Schedule of Civil Penalties. – The Board shall establish a schedule of civil penalties for violations of this Article. The schedule shall indicate for each type of violation whether the violation can be corrected. Penalties shall be assessed for the first, second, and third violations of specified sections of this Article and for specified rules.

(d) Costs. – The Board may, in an action brought under this section or in any other disciplinary proceeding, charge costs, including reasonable attorneys' fees, to the licensee against whom the proceedings were brought."

SECTION 9. This act becomes effective December 1, 2003, and applies to civil penalties assessed on or after that date.

HOUSE BILL 1257:
Amend Respiratory Care Practice Act/Fees

BILL ANALYSIS

Committee:	Sen. Health & Human Resources	**Introduced by:**	Reps. Tolson, Nye
Date:	July 15, 2003	**Summary by:**	Dianna Jessup
Version:	PCS H1257-CSSWf-60 [v.2]		Committee Counsel

SUMMARY: ***The second edition of HB 1257 amends various provisions under the Respiratory Care Practice Act described in more detail below. In addition, the second edition permits the North Carolina Respiratory Care Board (Board) to raise its fees up to an amount of increase in the Consumer Price Index, as long as the fees do not exceed costs. The bill becomes effective when it becomes law.***

The Proposed Committee Substitute makes technical changes to the Respiratory Care Practice Act, deletes the section of the bill that would permit the Board to raise its fees up to an amount of increase in the Consumer Price Index, and makes the bill become effective December 1, 2003. The changes made by the PCS are described in more detail below.

CURRENT LAW: The Respiratory Care Practice Act was enacted in 2000. Respiratory care, as defined by the written order of a licensed physician, is the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system. The Act sets up a 10-member Board, establishes licensure requirements, provides for the denial, suspension, and revocation of licenses, establishes fees, provides that a violation is a Class 1 misdemeanor, and exempts certain persons and practices from licensure.

BILL ANALYSIS:

- **Section 1** deletes a reference to NCHA under the Board's membership and replaces NCHA with its complete name, the North Carolina Hospital Association. *The second edition to the bill did NOT contain this provision.*

- **Section 2** authorizes the Respiratory Care Board to conduct background investigation of applicants for licensure.

- **Section 3** amends the requirements for licensure by requiring the applicant to submit written evidence to the Board that the applicant has completed the minimal requirements of a respiratory care education program approved by the Board. (Current law requires approval by the Commission for Accreditation of Allied Health Educational Programs.) In addition, this section amends requirements for licensure by requiring the applicant to submit written evidence to the Board that the applicant has completed the minimal requirements for Basic Cardiac Life Support as recognized by the Board. (Current law requires recognition by the American Heart Association.)

- **Section 4** provides that temporary licenses may be issued for up to 90 days from date of application. (Current law provides that a temporary license is valid until October 1, 2002)

- **Section 5** requires direct supervision of provisional licensees by respiratory care practitioners.

- **Section 6** establishes the following new fees:
  - A fee not to exceed $20 for official verification of licensure status
  - A fee not to exceed $150 for approval of continuing education programs

- **Section 7** deletes an outdated reference under the requirement of licensure section. *This provision was NOT in the second edition of the bill.*

- **Section 8** authorizes the Board to assess a civil penalty of up to $1,000 and charge costs, including reasonable attorneys' fees, to any licensee for violation of the Act and rules. The proceeds of any civil penalty will be remitted to the Civil Penalty and Forfeiture Fund established by the General Assembly.[1]

- **Section 9** makes the bill become effective December 1, 2003, and applies civil penalties assessed on or after that date. *The original bill made the bill become effective when it becomes law.*

The second edition to House Bill 1257 included a provision to amend Chapter 93B (Occupational Licensing Boards) to authorize occupational licensing boards to increase fees previously set by the General Assembly by an amount not to exceed the cumulative amount of the percentage increase in the Consumer Price Index since the fees were last adjusted. Boards would not be able to set fees by an amount that exceeds their regulatory and operating costs. In addition, boards would be required to publish notice of fee increases in the North Carolina Register and a newspaper of general circulation not less than 60 days before the fee increases become effective. Finally, boards would be required to annually report all fee increases to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division. The new language in Chapter 93B would have only applied to the North Carolina Respiratory Care Board.

THE PCS TO HB 1257 DELETES THIS PROVISION FROM THE BILL.

Amy Compeau, Research Assistant, and Martha Walston, Staff Counsel to the House Finance Committee, contributed substantially to this summary.

H1257-SMSW-003

[1] Article 31A of Chapter 115C of the General Statutes creates the Civil Penalty and Forfeiture Fund administered by the Office of State Budget and Management. This Fund consists of the proceeds of all civil penalties and civil forfeitures collected by a State agency. These proceeds are transferred to the State School Technology Fund and allocated to local school administrative units on the basis of average daily membership. Litigation is pending to determine several issues, including the issue of whether the N.C. Constitution requires that the proceeds go to the school fund of the county in which the violation occurred instead of the School Technology Fund. The parties are awaiting decision of the North Carolina Court of Appeals.

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 15, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Deborah Ramm	NCPNA/NCALHD
Wink Hilliard	NCSA
DAVID BARNES	Poyner Spruill LLP
Soren Schmidt	NC Justice Center
John Cyrus	NC State Treasurer
TOMMY SUTER	WYETH
Peyton MAYNARD	GR
Jim Blackburn	Association of County Commissioners

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 15, 2003**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom Williams	NC Society For Resp. Care Rex Hospital
Julie Allen	NC Statewatch
Floyd Boyer	NC Respiratory Care Board
Ralph D. Webb	NC Respiratory Care Board
[signature]	NCSA
[signature]	Staff
Allison Summerville	Staff Intern
Jessica Dawley	Covenant w/NC's Children
Ken Melton	Alley Associates, Inc.
Hal Miller	NCACCT
Adam Proleman	NCASA

AGENDA

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Friday, July 18, 2003 at 9:00 A.M.
Room 414, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bill to be Considered**

- **HB 932, Est. Reg'l. Interagency Coordinating Council**
  Rep. Alexander, Rep. Warren, Rep. Insko

III. **Other Business**

IV. **Adjournment**

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Friday, July 18, 2003 at 9:00 A.M.
Room 414, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 9:20 Friday, July 18, 2003, in Room 414 of the Legislative Office Building. Three members of the committee were present. Senator William Purcell presided.

Senator Purcell recognized Representative Martha Alexander to present her bill, HB 932, *Est. Reg. Interagency Coordinating Council*. She explained the history of the bill and its provisions. After a short discussion, Senator Malone moved that the bill receive a favorable report, and the motion passed.

The meeting adjourned at 9:35 A.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Friday, July 18, 2003

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

FAVORABLE

H.B.(CS #1) **932** Est. Reg'l. Interagency Coordinating Council.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 932

Committee Substitute Favorable 7/9/03

Short Title: Est. Reg'l. Interagency Coordinating Council. (Public)

Sponsors:

Referred to:

April 8, 2003

A BILL TO BE ENTITLED

AN ACT ESTABLISHING REGIONAL INTERAGENCY COORDINATING COUNCILS UNDER THE LAWS RELATING TO EARLY INTERVENTION SERVICES FOR CHILDREN FROM BIRTH TO FIVE YEARS OF AGE WITH DISABILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-179.5A. Regional Interagency Coordinating Councils for Children from Birth to Five with Disabilities and Their Families; establishment; composition; organization; duties; compensation; reporting.**

(a) There are established 18 Regional Interagency Coordinating Councils for Children from Birth to Five with Disabilities and Their Families, corresponding with the catchment areas for the Children's Developmental Services Agency of the Division of Public Health, Department of Health and Human Services.

(b) Each Regional Interagency Coordinating Council shall have no more than 30 members, appointed by the NC Interagency Coordinating Council (NC-ICC) and the Division of Public Health. Members of each Regional Council shall serve staggered terms. On or before January 1, 2004, the NC-ICC and the Division of Public Health shall designate no more than 15 appointees to serve for two-year terms on each Regional Council and no more than 15 appointees to serve for one-year terms on each Regional Council. Upon the expiration of the terms of the initial Regional Council members, each member shall be appointed for a term of two years and shall serve until a successor is appointed. The NC-ICC and the Division of Public Health shall have the power to remove any member of a Regional Council from office. Any appointment to fill a vacancy on a Regional Council created by the resignation, dismissal, death, or disability of a member shall be for the remainder of the unexpired term. Members may succeed themselves for one term and may be appointed again after being off a Regional

Council for one term. All members shall abide by the state interagency agreement of the NC Interagency Coordinating Council.

(c) The composition of Regional Councils shall be as follows:

(1) At least twenty percent (20%) parents or families of young children ages birth to five with disabilities for each region.

(2) One Local Interagency Coordinating Council (LICC) representative for each county in a region.

(3) The Children's Developmental Services Agency Director.

(4) One Regional Family Support Network representative for each region.

(5) One Local Management Entity representative for each region practicing in the area of mental health.

(6) One health department representative for each region.

(7) One executive director of a local Partnership for Children for each region.

(8) One local Department of Social Services representative for each region.

(9) One representative who is a member of the medical community for each region. Members appointed pursuant to this subdivision may include a pediatrician, or a health care provider, as defined in G.S. 58-50-61(8), at a local hospital, including a neonatal intensive care unit (NICU).

(10) One Head Start/Early Head Start representative for each region.

(11) One representative from the Office of Education Services Governor Morehead Early Intervention/Preschool Program for each region.

(12) One representative from the Office of Education Services Deaf/Hard of Hearing Early Intervention/Preschool Program for each region.

(13) One representative of the Regional TEACCH program.

(14) One representative of the Military Early Intervention program, if a military base is present in the region.

(15) Other public or private providers as recommended by LICCs within the region and as approved by the NC-ICC and the Division of Public Health.

(d) After a Regional Council has appointed its members, the Regional Council shall, at its first meeting, elect a parent and a professional as cochairs to establish any standing or ad hoc committees or task forces necessary to carry out the functions of the Regional Council. The Regional Council shall meet at least quarterly. A majority of the Regional Council will constitute a quorum for the transaction of business.

(e) Each Regional Council shall be responsible for developing an early intervention plan, in collaboration with the Children's Developmental Services Agency, for all eligible children ages birth to three years and their families in its designated area. The Regional Council shall specifically address in its early intervention plan, as indicated in the 'Individuals with Disabilities Education Act' (IDEA), P.L. 105-17, those efforts designated as local responsibilities, including the following:

(1) Implementing Child Find through public awareness activities.

(2) Ensuring the availability of early intervention required services through the assessment of service delivery capacity, the identification of needs, and the development or revision of plans to address gaps or inadequacies.

(3) Implementing policies for interagency professional development.

(4) Establishing methods for compliance monitoring and qualitative evaluation of services.

(5) Developing a plan of coordination and integration with other early childhood special education and related human service planning, such as that carried out by Mental Health Local Management Entities (LMEs), Smart Start, and Local Education Agencies (LEAs).

(f) Each Regional Interagency Coordinating Council shall prepare and submit an annual report to the NC-ICC and all regional early intervention agencies in its area. The annual report shall address the status of the early intervention system for eligible infants and toddlers in its respective region. Additionally, each Regional Council shall report quarterly to the NC-ICC on the development and implementation status of its regional early intervention plan. The Early Intervention Branch of the Division of Public Health shall make significant efforts to identify appropriate sources of non-State funds to support each Regional Council with staff and administrative support."

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

HOUSE BILL 932:
Est. Reg'l. Interagency Coordinating Council

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Rep. Alexander
		Summary by:	Sandra Alley Committee Counsel
Date:	July 17, 2003		
Version:	Second Edition		

SUMMARY: ***HB 932 would establish Regional Interagency Coordinating Councils for children from birth to five years of age with disabilities. It would also set out the duties, responsibilities and makeup of these councils.***

CURRENT LAW: Currently services to children, eligible for early intervention services, are provided either by Area Mental Health Authorities or by regional Children's Developmental Services Agencies (CDSAs, formerly Developmental Evaluation Centers, DECs). Prior to July 1, 2003, Area Mental Health Authorities were solely responsible for providing such services. However, under the mental health reform law passed by the General Assembly, Area Mental Health Authorities may opt to cease their responsibility for being the local lead agency for providing early intervention services and transfer the responsibility to CDSAs. CDSAs need support with developing and planning efficient methods of providing required early intervention services.

BILL ANALYSIS: HB 932 would establish Regional Interagency Coordinating Councils for children from birth to five years of age with disabilities. It would also set out the duties, responsibilities and makeup of these councils.

BACKGROUND: The 2001 Session of the General Assembly passed several Special Provisions related to early intervention. A Special Provision designated the Division of Public Health of DHHS as the state level lead agency responsible for early intervention services. Special Provision section 21.85(a)-(d) of Session Laws 2001-424 directed the Division of Public Health to complete an evaluation of how early intervention services are organized and provided locally. Also to submit a report describing how to gain efficiencies and effectiveness for available resources, while evaluating ways to combine early intervention services provided by the Developmental Evaluation Centers, regional therapists, local health departments, and area mental health authorities to gain efficiencies. A plan was submitted and accepted by the General Assembly. The plan called for regional councils to assist CDSAs in planning and implementing regional early intervention services. Regional Councils now need to be established.

H932-SMSP-001

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES- **JULY 18, 2003**
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Jo Horne	NCMS
K Chesson	NC - ICC
RB Hamm	H/H/S
Sante Piracci	Sen. Kinnaird
Cheryl Spivey	Citizen
Karen Mills	Citizen
John McHugh	Gov office
DAVID BARNES	Poyner + Spruill LLP
Mark Benson	Capitol Group
John I Bowdish	AstraZeneca

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Sunday, July 20, 2003 at 8:25 p.m.
Senate Chamber, Legislative Building

MINUTES

The Senate Health and Human Resources Committee met at 8:25 p.m. on Sunday, July 20, 2003, in the Senate Chamber of the Legislative Building. Seven members of the committee were present. Senator William Purcell presided.

Senator Purcell recognized Senator Jeanne Lucas to move adoption of a proposed committee substitute for HB 354, Child Lead Poisoning Prevention Prgm Amends.-AB. The motion carried. Senator Vernon Malone moved an unfavorable report of the bill, but favorable report of the committee substitute. The motion carried.

The meeting adjourned at 8:30 p.m.

William R Purnell — Dot Waugaman

Senator William Purcell, Chair — Dot Waugaman, Acting Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Sunday, July 20, 2003

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) **354** Child Lead Poisoning Prevention Prgm Amends.-AB

Draft Number:	PCS 30423
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 354

Committee Substitute Favorable 4/7/03

Short Title: Child Lead Poisoning Prevention Prgm Amends.-AB (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW REGARDING THE PREVENTION AND CONTROL OF LEAD POISONING IN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-131.7 reads as rewritten:

"**§ 130A-131.7. Definitions.**

~~As used in this Part, unless the context requires otherwise, the term:~~The following definitions apply in this Part:

(1) "Abatement" means undertaking any of the following measures to eliminate a lead-based paint hazard:

a. Removing lead-based paint from a surface and repainting the surface.

b. Removing a component, such as a windowsill, painted with lead-based paint and replacing the component.

c. Enclosing a surface painted with lead-based paint with paneling, vinyl siding, or another approved material.

d. Encapsulating a surface painted with lead-based paint with a sealant.

e. Any other measure approved by the Commission.

(2) "Child-occupied facility" means a building, or portion of a building, constructed ~~prior to~~before 1978, regularly visited by a child who is less than ~~6~~ six years of age. Child-occupied facilities may include, but are not limited to, child care facilities, preschools, nurseries, kindergarten classrooms, schools, clinics, or treatment centers including the common areas, the grounds, any outbuildings, or other structures appurtenant to the facility.

(3) "Confirmed lead poisoning" means a blood lead concentration of 20 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(4) "Department" means the Department of Environment and Natural Resources or its authorized agent.

(5) "Elevated blood lead level" means a blood lead concentration of 10 micrograms per deciliter or greater determined by the lower of two consecutive blood tests within a six-month period.

(6) "Lead-based paint hazard" means a condition that is likely to ~~cause adverse health effects as a~~ result ~~of~~ in exposure to lead-based paint or to soil or dust that contains lead ~~derived from lead-based paint.~~at a concentration that constitutes a lead poisoning hazard.

(7) "Lead poisoning hazard" means any of the ~~presence of readily accessible or mouthable lead-bearing substances, including lead-based paint, measuring 1.0 milligram per square centimeter or greater by X-ray fluorescence or five-tenths of one percent (0.5%) or greater by chemical analysis; or 15 parts per billion or greater in drinking water; or 100 micrograms per square foot or greater for dust on floors; or 500 micrograms per square foot or greater for dust on windowsills; or 800 micrograms per square foot or greater for dust in window troughs, or soil lead concentrations in an amount greater than or equal to 400 parts per million that is determined by the Department to present a hazard in light of (i) the condition and use of the land and (ii) other relevant factors.~~following:

a. Any lead-based paint or other substance that contains lead in an amount equal to or greater than 1.0 milligrams lead per square centimeter as determined by X-ray fluorescence or five-tenths of a percent (0.5%) lead by weight as determined by chemical analysis: (i) on any readily accessible substance or chewable surface on which there is evidence of teeth marks or mouthing; or (ii) on any other deteriorated or otherwise damaged interior or exterior surface.

b. Any substance that contains lead intended for use by children less than six years of age in an amount equal to or greater than 0.06 percent (0.06%) lead by weight as determined by chemical analysis.

c. Any concentration of lead dust that is equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills, vinyl miniblinds, bathtubs, kitchen sinks, or lavatories.

d. Any lead-based paint or other substance that contains lead on a friction or impact surface that is subject to abrasion, rubbing, binding, or damage by repeated contact and where the lead dust concentrations on the nearest horizontal surface underneath the friction or impact surface are equal to or greater than 40 micrograms per square foot on floors or 250 micrograms per square foot on interior windowsills.

e. Any concentration of lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of a residential housing unit or child-occupied facility equal to or greater than 400 parts per million. Any concentration of lead in bare soil in other locations of the yard equal to or greater than 1,200 parts per million.

f. Any ceramic ware generating equal to or greater than three micrograms of lead per milliliter of leaching solution for flatware or 0.5 micrograms of lead per milliliter for cups, mugs, and pitchers as determined by Method 973.32 of the Association of Official Analytical Chemists.

g. Any concentration of lead in drinking water equal to or greater than 15 parts per billion.

(8) "Lead-safe housing" is housing that was built since 1978 or has been tested by a person that has been certified to perform risk assessments and found to have no lead-based paint hazard within the meaning of the Residential Lead-Based Paint Reduction Act of 1992, 42 U.S.C. § 4851b(15).

(9) "Maintenance standard" means the following:

a. Using safe work practices, repairing and repainting areas of deteriorated paint inside a residential housing unit and for single-family and duplex residential dwelling built ~~prior to~~before 1950, repairing and repainting areas of deteriorated paint on interior and exterior surfaces;

b. Cleaning the interior of the unit to remove dust that constitutes a lead poisoning hazard;

c. Adjusting doors and windows to minimize friction or impact on surfaces;

d. Subject to the occupant's approval, appropriately cleaning any carpets;

e. Taking such steps as are necessary to ensure that all interior surfaces on which dust might collect are readily cleanable; and

f. Providing the occupant or occupants all information required to be provided under the Residential Lead-Based Paint Hazard Reduction Act of 1992, and amendments thereto.

(10) "Managing agent" means any person who has charge, care, or control of a building or part thereof in which dwelling units or rooming units are leased.

(11) ~~"Mouthable lead-bearing substance" means any substance on surfaces or fixtures five feet or less from the floor or ground that form a protruding corner or similar edge, or protrude one-half inch or more from a flat wall surface, or are freestanding, containing lead-contaminated dust at a level that constitutes a lead poisoning hazard. Mouthable surfaces or fixtures include toys, vinyl miniblinds,~~

~~doors, door jambs, stairs, stair rails, windows, windowsills, and baseboards.~~

(12) ~~"Persistent elevated blood lead level" means a blood lead concentration of 15-19 micrograms per deciliter determined by the lowest of three consecutive blood tests. The first two blood tests shall be performed within a six month period, and the third blood test shall be performed at least 12 weeks and not more than six months after the second blood test.~~

(13) "Readily accessible ~~lead-bearing~~ substance" means any substance ~~containing lead at a level that constitutes a lead poisoning hazard which~~that can be ingested or inhaled by a child ~~under 6~~less than six years of age. Readily accessible substances include deteriorated paint that is peeling, chipping, cracking, flaking, or blistering to the extent that the paint has separated from the substrate. Readily accessible substances also include soil, ~~water,~~water, toys, vinyl miniblinds, bathtubs, lavatories, doors, door jambs, stairs, stair rails, windows, interior windowsills, baseboards, and paint that is chalking.

(14) "Regularly visits" means the presence at a residential housing unit or child-occupied facility on at least two different days within any week, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours, and the combined annual visits last at least 60 hours.

(15) "Remediation" means the elimination or control of lead poisoning hazards by methods approved by the Department.

(16) "Residential housing unit" means a dwelling, dwelling unit, or other structure, all or part of which is designed or used for human habitation, including the common areas, the grounds, any outbuildings, or other structures appurtenant to the residential housing unit.

(17) "Supplemental address" means a residential housing unit or child-occupied facility where a child with ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning regularly visits or attends. Supplemental address also means a residential housing unit or child-occupied facility where a child resided, regularly visited, or attended within the six months immediately preceding the determination of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning."

SECTION 2. G.S. 130A-131.8 reads as rewritten:

"**§ 130A-131.8. Reports of blood levels in children.**

All laboratories doing business in this State shall report to the Department all blood lead ~~levels of one microgram per deciliter or greater~~test results for children less than ~~6~~ six years of age and for individuals whose ages are unknown at the time of testing. Reports shall be made within five working days after test completion on forms provided by the Department or on self-generated forms containing: the child's full name, date of birth, sex, race, address, and Medicaid number, if any; the name, address, and telephone

number of the requesting health care provider; the name, address, and telephone number of the testing laboratory; the laboratory results, the specimen type – venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed. ~~Such~~The reports may be made by electronic submissions."

SECTION 3. G.S. 130A-131.9 reads as rewritten:

"**§ 130A-131.9. Examination and testing.**

When the Department has a reasonable suspicion that a child less than ~~6~~ six years of age has ~~a persistent~~ an elevated blood lead level or a confirmed lead poisoning, the Department may require that child to be examined and tested within 30 days. The Department shall require from the owner, managing agent, or tenant of the residential housing unit or child-occupied facility information on each child who resides in, regularly visits, or attends, or, who has within the past six months, resided in, regularly visited, or attended the unit or facility. The information required shall include each child's name and date of birth, the names and addresses of each child's parents, legal guardian, or full-time custodian. The owner, managing agent, or tenant shall submit the required information within 10 days of receipt of the request from the Department."

SECTION 4. G.S. 130A-131.9A reads as rewritten:

"**§ 130A-131.9A. Investigation to identify lead poisoning hazards.**

(a) When the Department learns of ~~a persistent elevated blood lead level or a~~ confirmed lead poisoning, the Department shall conduct an investigation to identify the lead poisoning hazards to children. The Department shall investigate the residential housing unit ~~or child-occupied facility~~ where the child with ~~the persistent elevated blood lead level or the~~ confirmed lead poisoning ~~resides, regularly visits, or attends.~~resides. The Department shall also investigate the supplemental addresses of the child who has ~~a persistent elevated blood lead or a~~ confirmed lead poisoning.

(a1) When the Department learns of an elevated blood lead level, the Department shall, upon informed consent, investigate the residential housing unit where the child with the elevated blood level resides. When consent to investigate is denied, the child with the elevated blood lead level cannot be located, or the child's parent or guardian fails to respond, the Department shall document the denial of consent, inability to locate, or failure to respond.

(b) The Department shall also conduct an investigation when it reasonably suspects that a lead poisoning hazard to children exists in a residential housing unit or child-occupied facility occupied, regularly visited, or attended by a child less than ~~6~~ six years of age.

(c) In conducting an investigation, the Department may take samples of surface materials, or other materials suspected of containing lead, for analysis and testing. If samples are taken, chemical determination of the lead content of the samples shall be by atomic absorption spectroscopy or equivalent methods approved by the Department."

SECTION 5. G.S. 130A-131.9B reads as rewritten:

"**§ 130A-131.9B. Notification.**

Upon determination that a lead poisoning hazard exists, the Department shall give written notice of the lead poisoning hazard to the owner or managing agent of the residential housing unit or child-occupied facility and to all persons residing in,

attending, or regularly visiting the unit or facility. The written notice to the owner or managing agent shall include a list of possible methods of ~~abatement of the lead-based paint hazards and of possible methods of remediation of any other lead poisoning hazard~~. remediation."

SECTION 6. G.S. 130A-131.9C reads as rewritten:

"**§ 130A-131.9C. ~~Abatement and remediation.~~Remediation.**

(a) Upon determination that a child less than ~~6~~ six years of age has a confirmed lead poisoning of 20 micrograms per deciliter or greater and that child resides ~~in, attends, or regularly visits,~~in a residential housing unit ~~or child-occupied facility~~ containing lead poisoning hazards, the Department shall require ~~abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards. The Department shall also require ~~the abatement of the lead-based paint hazards and the~~ remediation of ~~other~~ the lead poisoning hazards identified at the supplemental addresses of a child less than ~~6~~ six years of age with a confirmed lead poisoning of 20 micrograms per deciliter or greater.

(b) When ~~abatement of lead-based paint hazards or~~ remediation of ~~other~~ lead poisoning hazards is required under subsection (a) of this section, the owner or managing agent shall submit a written remediation plan to the Department within 14 days of receipt of the lead poisoning hazard notification and shall obtain written approval of the plan ~~prior to~~before initiating ~~abatement of lead-based paint hazards or~~ remediation ~~of other lead poisoning hazards.~~activities. The remediation plan shall comply with subsections (g), (h), and (i) of this section.

(c) If the remediation plan submitted fails to meet the requirements of this section, the Department shall issue an order requiring submission of a modified plan. The order shall indicate the modifications ~~which~~ that shall be made to the remediation plan and the date ~~by which~~that the plan as modified shall be submitted to the Department.

(d) If the owner or managing agent does not submit a remediation plan within 14 days, the Department shall issue an order requiring submission of a remediation plan within five days of receipt of the order.

(e) The owner or managing agent shall notify the Department and the occupants of the dates of remediation activities at least three days ~~prior to the~~before commencement of the activities.

(f) ~~Abatement of lead-based paint hazards and remediation~~Remediation of ~~other~~ the lead poisoning hazards shall be completed within 60 days of the Department's approval of the remediation plan. If ~~these~~ the remediation activities are not completed within 60 ~~days as required,~~days, the Department shall issue an order requiring completion of the activities. An owner or managing agent may apply to the Department for an extension of the deadline. The Department may issue an order extending the deadline for 30 days upon proper written application by the owner or managing agent.

(g) ~~The~~ All of the following methods of ~~abatement~~ remediation of lead-based paint hazards are prohibited:

(1) Stripping paint on-site with methylene chloride-based ~~solutions;~~solutions.

(2) Torch or flame ~~burning;~~burning.
(3) Heating paint with a heat gun above 1,100 degrees ~~Fahrenheit;~~Fahrenheit.
(4) Covering with new paint or wallpaper unless all readily accessible lead-based paint has been ~~removed;~~removed.
(5) Uncontrolled abrasive ~~blasting; or~~ blasting, machine sanding, or grinding, except when used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at ninety-nine and seven-tenths percent (99.7%) or greater efficiency.
(6) Uncontrolled waterblasting.
(7) Dry scraping, unless used in conjunction with heat guns, or around electrical outlets, or when treating no more than two square feet on interior surfaces, or no more than 20 square feet on exterior surfaces.

(h) All lead-containing waste and residue shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules. Other substances containing lead that are intended for use by children less than six years of age and vinyl miniblinds that constitute a lead poisoning hazard shall be removed and disposed of in accordance with applicable federal, State, and local laws and rules.

(i) All remediation plans shall require that the lead poisoning hazards be reduced to ~~below~~ the following levels:

(1) ~~Floor lead dust levels~~Less ~~are less~~ than ~~100~~ 40 micrograms per square ~~foot;~~foot for lead dust on floors.
(2) ~~Windowsill lead dust levels are less~~Less than ~~500~~ 250 micrograms per square ~~foot;~~foot for lead dust on interior windowsills, bathtubs, kitchen sinks, and lavatories.
(3) ~~Window trough lead dust levels are less~~Less than ~~800~~ 400 micrograms per square ~~foot;~~foot for lead dust on window troughs.
(4) ~~Soil lead levels are less~~Less than 400 parts per million ~~or such other level higher than 400 parts per million as determined by the Department to prevent a hazard in light of the condition and use of the land and in light of other relevant factors; and~~for lead in bare soil in play areas, gardens, pet sleeping areas, and areas within three feet of the residential housing unit or child-occupied facility. Lead in bare soil in other locations of the yard shall be reduced to less than 1,200 parts per million.
(5) ~~Drinking water lead levels less~~ Less than 15 parts per ~~billion.~~ billion for lead in drinking water.

(j) The Department shall verify by visual inspection that the approved remediation plan has been completed. The Department may also verify plan completion by residual lead dust monitoring and soil or drinking water lead level measurement.

(j1) Compliance with the maintenance standard satisfies the remediation requirements for confirmed lead poisoning cases identified on or after 1 October 1990 as long as all lead poisoning hazards identified on interior and exterior surfaces are

addressed by remediation. Except for owner-occupied residential housing units, continued compliance shall be verified by means of an annual monitoring inspection conducted by the Department. For owner-occupied residential housing units, continued compliance shall be verified (i) by means of an annual monitoring inspection, (ii) by documentation that no child less than six years of age has resided in or regularly visited the residential housing unit within the past year, or (iii) by documentation that no child less than six years of age residing in or regularly visiting the unit has an elevated blood lead level.

(k) Removal of children from the residential housing unit or child-occupied facility shall not constitute ~~abatement or~~ remediation if the property continues to be used for a residential housing unit or child-occupied ~~facility.~~facility. The remediation requirements imposed in subsection (a) of this section apply so long as the property continues to be used as a residential housing unit or child-occupied facility."

SECTION 7. G.S. 130A-131.9G reads as rewritten:

"**§ 130A-131.9G. Resident responsibilities.**

In any residential housing unit occupied by a child less than ~~6~~ six years ~~old~~ of age who has an elevated blood lead level of 10 micrograms per deciliter or greater, the Department shall advise, in writing, the owner or managing agent and the child's parents or legal guardian ~~as to~~of the importance of carrying out routine cleaning activities in the units they occupy, own, or manage. ~~Such~~ The cleaning activities shall ~~include:~~include all of the following:

(1) Wiping clean all windowsills with a damp cloth or sponge at least ~~weekly;~~weekly.

(2) Regularly washing all surfaces accessible to ~~children;~~children.

(3) In the case of a leased residential housing unit, identifying any deteriorated paint in the unit and notifying the owner or managing agent of ~~such~~ the conditions within 72 hours of ~~discovery; and~~discovery.

(4) Identifying and understanding potential lead poisoning hazards in the environment of each child ~~under the age of 6~~ less than six years of age in the unit (including toys, vinyl miniblinds, playground equipment, drinking water, soil, and painted surfaces), and taking steps to prevent children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

SECTION 8. This act becomes effective 1 July 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 354

Committee Substitute Favorable 4/7/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H354-PCS30423-ST-67

Short Title: Amend Disability Laws. (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STATE DISABILITY INCOME PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. Section 30.20.(k) of S.L. 2003-284 is repealed.

SECTION 2. G.S. 135-106(a), as rewritten by Section 30.20.(l) of S.L. 2003-284, reads as rewritten:

"(a) Upon the application of a beneficiary or participant or of his legal representative or any person deemed by the Board of Trustees to represent the participant or beneficiary, any beneficiary or participant who has had five or more years of membership service may receive long-term disability benefits from the Plan upon approval by the Board of Trustees, commencing on the first day succeeding the conclusion of the short-term disability period provided for in G.S. 135-105, provided the beneficiary or participant makes application for such benefit within 180 days after the short-term disability period ceases, after salary continuation payments cease, or after monthly payments for Workers' Compensation cease, whichever is later; Provided, that the beneficiary or participant withdraws from active service by terminating employment as a teacher or State employee; Provided, that the Medical Board shall certify that such beneficiary or participant is unable to perform any occupation ~~for which the beneficiary or participant is reasonably qualified for by~~ or employment commensurate to the beneficiary's or participant's education, training or experience, which is available in the same commuting area for State employees or within the same local school administrative unit for school personnel, without an adverse impact on the beneficiary's or participant's career status, and in which the beneficiary or participant can be expected to earn not less than sixty-five percent (65%) of that beneficiary's or participant's predisability earnings, that such incapacity was incurred at the time of active employment and has been continuous thereafter, that such incapacity is likely to be permanent; Provided further that the Medical Board shall not certify any beneficiary or

participant as disabled who is in receipt of any payments on account of the same incapacity which existed when the beneficiary first established membership in the Retirement System. The Board of Trustees may extend this 180-day filing requirement upon receipt of clear and convincing evidence that application was delayed through no fault of the disabled beneficiary or participant and was delayed due to the employers' miscalculation of the end of the 180-day filing period. However, in no instance shall the filing period be extended beyond an additional 180 days.

The Board of Trustees may require each beneficiary who becomes eligible to receive a long-term disability benefit to have an annual medical review or examination for the first five years and thereafter once every three years after the commencement of benefits under this section. However, the Board of Trustees may require more frequent examinations and upon the advice of the Medical Board shall determine which cases require such examination. Should any beneficiary refuse to submit to any examination required by this subsection or by the Medical Board, his long-term disability benefit shall be suspended until he submits to an examination, and should his refusal last for one year, his benefit may be terminated by the Board of Trustees. If the Medical Board finds that a beneficiary is no longer unable to perform any occupation for which the beneficiary or participant is reasonably qualified for by training or experience, the Department of State Treasurer and the Board of Trustees may terminate the beneficiary's long-term disability benefits effective on the last day of the month in which the Medical Board certifies that the beneficiary is no longer disabled.

As to the requirement of five years of membership service, any participant or beneficiary who does not have five years of membership service within the 96 calendar months prior to conclusion of the short-term disability period or cessation of salary continuation payments, whichever is later, shall not be eligible for long-term disability benefits.

Notwithstanding the requirement that the incapacity was incurred at the time of active employment, any participant who becomes disabled while on an employer approved leave of absence and who is eligible for and in receipt of temporary total benefits under The North Carolina Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, will be eligible for all benefits provided under this Article."

SECTION 3. Section 1 of this act becomes effective July 1, 2003. Section 2 of this act becomes effective July 1, 2004, and applies only to persons who are not vested in the disability plan in question on July 1, 2004. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

H D

HOUSE BILL 354
Committee Substitute Favorable 4/7/03
PROPOSED SENATE COMMITTEE SUBSTITUTE H354-CSST-67 [v.2]

7/20/2003 8:19:51 PM

Short Title: Amend Disability Laws. (Public)

Sponsors:

Referred to:

March 6, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STATE DISABILITY INCOME PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. Section 30.20.(k) of S.L. 2003-284 is repealed.

SECTION 2. G.S. 135-106(a), as rewritten by Section 30.20.(l) of S.L. 2003-284, reads as rewritten:

"(a) Upon the application of a beneficiary or participant or of his legal representative or any person deemed by the Board of Trustees to represent the participant or beneficiary, any beneficiary or participant who has had five or more years of membership service may receive long-term disability benefits from the Plan upon approval by the Board of Trustees, commencing on the first day succeeding the conclusion of the short-term disability period provided for in G.S. 135-105, provided the beneficiary or participant makes application for such benefit within 180 days after the short-term disability period ceases, after salary continuation payments cease, or after monthly payments for Workers' Compensation cease, whichever is later; Provided, that the beneficiary or participant withdraws from active service by terminating employment as a teacher or State employee; Provided, that the Medical Board shall certify that such beneficiary or participant is unable to perform any occupation ~~for which the beneficiary or participant is reasonably qualified for by~~ or employment commensurate to the beneficiary's or participant's education, training or experience, which is available in the same commuting area for State employees or within the same local school administrative unit for school personnel, without an adverse impact on the beneficiary's or participant's career status, and in which the beneficiary or participant can be expected to earn not less than sixty-five percent (65%) of that beneficiary's or participant's predisability earnings, that such incapacity was incurred at the time of active employment and has been continuous thereafter, that such incapacity is likely to be permanent; Provided further that the Medical Board shall not certify any beneficiary or

participant as disabled who is in receipt of any payments on account of the same incapacity which existed when the beneficiary first established membership in the Retirement System. The Board of Trustees may extend this 180-day filing requirement upon receipt of clear and convincing evidence that application was delayed through no fault of the disabled beneficiary or participant and was delayed due to the employers' miscalculation of the end of the 180-day filing period. However, in no instance shall the filing period be extended beyond an additional 180 days.

The Board of Trustees may require each beneficiary who becomes eligible to receive a long-term disability benefit to have an annual medical review or examination for the first five years and thereafter once every three years after the commencement of benefits under this section. However, the Board of Trustees may require more frequent examinations and upon the advice of the Medical Board shall determine which cases require such examination. Should any beneficiary refuse to submit to any examination required by this subsection or by the Medical Board, his long-term disability benefit shall be suspended until he submits to an examination, and should his refusal last for one year, his benefit may be terminated by the Board of Trustees. If the Medical Board finds that a beneficiary is no longer unable to perform any occupation for which the beneficiary or participant is reasonably qualified for by training or experience, the Department of State Treasurer and the Board of Trustees may terminate the beneficiary's long-term disability benefits effective on the last day of the month in which the Medical Board certifies that the beneficiary is no longer disabled.

As to the requirement of five years of membership service, any participant or beneficiary who does not have five years of membership service within the 96 calendar months prior to conclusion of the short-term disability period or cessation of salary continuation payments, whichever is later, shall not be eligible for long-term disability benefits.

Notwithstanding the requirement that the incapacity was incurred at the time of active employment, any participant who becomes disabled while on an employer approved leave of absence and who is eligible for and in receipt of temporary total benefits under The North Carolina Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, will be eligible for all benefits provided under this Article."

SECTION 3. Section 1 of this act becomes effective July 1, 2003. Section 2 of this act becomes effective July 1, 2004, and applies only to persons who are not vested in the disability plan in question on July 1, 2004. The remainder of this act is effective when it becomes law.

BUCK CONSULTANTS
A Mellon Financial Company
200 Galleria Parkway NW, Suite 1900
Atlanta, Georgia 30339-5945

July 16, 2003

Ms. Joanne Scharer
Policy Director
Retirement Systems Division
Department of State Treasurer
325 North Salisbury Street
Raleigh, NC 27603-1385

House Bill 281 – Amendment to Budget Bill

Dear Ms. Scharer:

We have received Marshall Barnes' email of July 15 regarding House Bill 281 – Amendment to Budget Bill, which affects the Disability Income Plan.

Section 91(a) appears to repeal Section 30.20 (k) of S.L. 2003-284. Section 91(b) appears to change the eligibility for the receipt of long-term disability benefits by requiring that a beneficiary or participant is unable to perform any occupation or employment for which the beneficiary or participant is reasonably qualified to perform, whether due to education, training or experience, which is available in the same commuting area for State employees or within the same local school administrative unit for school personnel, without an adverse impact on the beneficiary's or participant's career status, and in which the beneficiary or participant can be expected to earn not less than sixty-five percent (65%) of that beneficiary or participant's predisability earnings.

As a result of this proposed legislation, there would be some savings under the Disability Income Plan due to this change in the definition of disability.

If we can be of further assistance with regard to this legislation, please do not hesitate to contact us.

Sincerely,

Edward A. Macdonald
Principal, Consulting Actuary

EAM:sh

P:\North Carolina LTD\Data\Correspondence\House bill 281.doc
3029 RET03-013

Buck Consultants, Inc.
770 | 955-2488 Fax 770 | 933-8336

Lorraine Blake (Sen. Purcell)

From: Lorraine Blake (Sen. Purcell)
Sent: Wednesday, May 19, 2004 9:49 AM
Cc: Rep. Paul Miller; Sen. A.B. Swindell
Subject: May 26, 2004, Health & Human Resources Committee Meeting Notice

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health and Human Resources** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 26, 2004	11:00 AM	544, LOB

The following will be considered:

	BILL NO.	SHORT TITLE	SPONSOR
•	HB 1256	Voluntary DNA Database	Representative Miller
•	SB 1150	Study Mentally Ill LTC Resident Issues	Senator Swindell

Senator William Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

CORRECTED NOTICE
S.B. 1218 has been added.

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health and Human Resources** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 26, 2004	11:00 AM	544, LOB

The following will be considered:

	BILL NO.	SHORT TITLE	SPONSOR
•	HB 1256	Voluntary DNA Database	Representative Miller
•	SB 1150	Study Mentally Ill LTC Resident Issues	Senator Swindell
•	SB 1218	Child Restraint Systems Modified	Senator Purcell

Senator William Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Senate Health & Human Resources Committee

Wednesday, May 26, 2004

544 LOB

Welcome and Opening Remarks: Senators Purcell and Bingham

Introduction of Pages: Senator Purcell

Bills:	HB 1256	Voluntary DNA Database	Representative Miller
	SB 1150	Study Mentally Ill LTC Resident Issues	Senator Swindell
	SB 1218	Child Restraint Systems Modified	Senator Purcell

Presentation: Mr. Tom Vitaglione, Senior Fellow, NC Child Advocacy Institute; Co-Chair Child Fatality Task Force

Other Business:

Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, May 26, 2004 at 11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M., Wednesday, May 26, 2004, in Room 544 of the Legislative Office Building. Ten members of the Committee were present. Senator William Purcell presided.

Senator Purcell recognized Senator A. B. Swindell to present SB 1150, *Study Mentally Ill LTC Resident Issues*. Senator Lucas asked if this is a study bill, and Senator Swindell replied that it is. After a short discussion, Senator Lucas moved that the bill receive a favorable report, and the motion passed. It will be sent on to the Appropriations Committee.

Senator Purcell asked Representatives Miller and Walend to explain HB 1256, *Voluntary DNA Database.* Before beginning discussion he announced that the bill would be heard by the Committee, but not voted on at this meeting. A proposed committee substitute was brought forward and adopted. Representative Walend pointed out that no funds from the General Fund would be used to implement this act, that it would be funded as authorized funds become available; that contributions and donations would fund this database in the same way that the Amber Alert is funded. Senator Reeves asked about the voluntary nature of DNA donations. Rep. Miller replied that donations would be collected in the same anonymous manner as blood donations. Senator Lucas asked where funding would come from. Rep. Miller said that funds would be sought from pharmaceutical companies or research institutions. If no such funds are forthcoming, then there would be no program. Senator Allran asked if there is any negative aspect or downside to the project and Rep. Miller replied that there is none. He said that details of a Fiscal Note are still being worked out, based on administrative aspects. Senator Forrester asked if there is a possibility that this could be used for babies at birth, possibly to follow genetic defects. Rep. Miller said that while it might be useful, that would not provide medical tracking information and provide medical markers as from a 70-year old person. Senator Lucas asked how much money would be needed to get the DNA database started. Rep. Miller said that the base cost would be about $65,000; the recurring cost would be about $270.000. There would be such costs as a DNA test kit; a refrigerator holding several thousand samples, about $10,000; a computer server about $50,000. Senator Lucas asked who would be overseeing all this. Rep. Miller said that the NC Central University chancellor would appoint a director who would be responsible for administration of this program. He also stated that this program could become self-funded in time. Senator Purcell asked if there is an industry that has asked for this program and is willing to pay for it. Rep. Miller answered that there are research institutions that want this information and pay for it now. Senator Purcell said that the N.C. Biosciences Association is meeting today to discuss this issue and that feedback from that group might be helpful before proceeding further on this bill. He thanked Representatives Miller and Walend for their presentation.

Senator Purcell turned chairmanship over to Co-Chair Senator Bingham in order that he could present his bill, SB 1218, *Child Restraint Systems Modified.* Senator Purcell called on Tom Vitaglione to describe provisions of the bill, which he did. He also said that the penalty for not placing a child in such a booster seat is $25, but would be waived if a booster seat is shown in court. The booster seats cost between $15 and $25. Senator Dannelly moved for a favorable report. The motion passed.

The meeting adjourned at 11:40 A.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 26, 2004

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

FAVORABLE

S.B. **1150** Study Mentally Ill LTC Resident Issues.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

S.B. **1218** Child Restraint Systems Modified.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 1150

Short Title:	Study Mentally Ill LTC Resident Issues.	(Public)
Sponsors:	Senators Swindell, Allran, Dannelly, Moore, Queen; Bingham, Dalton, Hargett, Holloman, Kerr, Kinnaird, Lucas, Malone, and Purcell.	
Referred to:	Health & Human Resources.	

May 18, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall work with long-term care providers and advocates for the elderly and the mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The study shall include:

(1) Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities.

(2) Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.

(3) Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living.

(4) Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.

(5) Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents are safeguarded.

(6) Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes

including the potential cost associated with implementing the recommendations.

SECTION 2. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The Department of Health and Human Services shall include in this report how it defines "mentally ill" for purposes of this study.

SECTION 3. The Department of Health and Human Services may use up to one hundred fifty thousand dollars ($150,000) of funds appropriated to it for the 2004-2005 fiscal year to contract for the study required in this act.

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

NC Child Fatality Task Force

SPECIAL BRIEFING ON CHILD PASSENGER SAFETY: BOOSTER SEATS

Recommendation

Children between the ages of four and eight and less than 80 pounds in weight who are occupants of passenger vehicles should be properly secured in belt-positioning booster seats.

Background and Rationale

- Under current North Carolina law, a child less than five years of age and less than 40 pounds in weight must be properly secured in a "weight-appropriate child passenger restraint system", commonly called a child restraint or car safety seat. At age five or 40 pounds (whichever comes first), children may be secured with properly fitted seat belts.

- The National Highway Traffic Safety Administration and the American Academy of Pediatrics recommend that children who are too big for car safety seats but are less than age 8 should be restrained by use of a belt positioning booster seat to make the adult lap and shoulder belts fit correctly on the child.

- In the period 2000-2002 alone, the State Center for Health Statistics confirms that 43 children ages 5 to 8 who were occupants of passenger vehicles were killed in motor vehicle crashes, and data from the UNC Highway Safety Research Center indicate that approximately 200 additional children were seriously injured. Based on police collision reports, only 7% of these children were reported to be in booster seats; 55% were restrained only by lap and/or shoulder belts; 38% were unrestrained.

- Research by Partners for Child Passenger Safety confirms that the use of a booster seat with a seat belt, instead of a seat belt alone, reduces a child's risk of death or serious injury by 59%. The most common serious injury is brain damage. The brain is the organ least likely to recover from injury.

- Responding to this information, 22 states and the District of Columbia have already enacted legislation to require the use of booster seats. This includes our neighboring states: Tennessee, Virginia and South Carolina.

- The use of belt positioning booster seats is recommended nationally by the American Academy of Pediatrics, the National Highway Transportation and Safety Administration, the National Safety Council, the Centers for Disease Control and Prevention, National SAFE KIDS Campaign, and others.

Special Notes:

- Backless booster seats are available for as low as $15; high-back models for as low as $25. There are already a number of local programs that make booster seats and child safety seats available at low cost. These programs also help to make sure all family members are as safe as possible.
- Penalties remain the same as current law. A violation includes a $25 fine and two driver's license points. A violation is waived if a booster seat is acquired before trial.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 1218

Short Title:	Child Restraint Systems Modified.	(Public)
Sponsors:	Senators Purcell; Allran, Bingham, Dannelly, Dorsett, and Lucas.	
Referred to:	Health & Human Resources.	

May 20, 2004

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE CHILD RESTRAINT SYSTEM REQUIREMENTS AS RECOMMENDED BY THE CHILD FATALITY TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-137.1(a1) reads as rewritten:

"(a1) A child less than ~~five~~ eight years of age and less than ~~40~~80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. A child less than eight years of age and more than 40 but less than 80 pounds in weight may be restrained only by a properly fitted lap belt only if all seating positions equipped with lap and shoulder belts are occupied."

SECTION 2. G.S. 20-137.1(c) reads as rewritten:

"(c) Any driver found responsible for a violation of this section may be punished by a penalty not to exceed twenty-five dollars ($25.00), even when more than one child less than 16 years of age was not properly secured in a restraint system. No driver charged under this section for failure to have a child under ~~five~~ eight 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 3. This act becomes effective October 1, 2004.

SENATE BILL 1218:
Child Restraint Systems Modified.

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Senator Purcell
Date:	May 26, 2004	**Summary by:**	Sara Kamprath
Version:	First Edition		Committee Analyst

SUMMARY: ***Senate Bill 1218 increases the age and weight requirements for children who must be secured in a child passenger restraint system. The bill also allows for a child under the age of 8 and weighing more than 40 but less than 80 pounds to be restrained by only a lap belt when all the lap and shoulder belt seating is occupied.***

The bill is a recommendation of the Child Fatality Task Force. The bill becomes effective October 1, 2004.

BILL ANALYSIS:

Children who must be Properly Secured in a Weight-Appropriate Child Passenger Restraint System

Current Law	Proposed in SB 1218
Less than 5 years old and	Less than 8 years old and
Less than 40 pounds	Less than 80 pounds

The bill also allows children who are under 8 years old and weigh more than 40 but less than 80 pounds to use only a properly fitted lap belt when all the other seats equipped with lap and shoulder belts are occupied.

BACKGROUND: The National Highway Traffic Safety Administration (NHTSA) and the American Academy of Pediatrics recommend that young children between 4 and 8 weighing over 40 pounds should use a belt positioning booster seat. Belt positioning booster seats must be used with both lap and shoulder belts. After a child is over age 8 or is 4'9" tall then they can use seat belts without a belt positioning booster seat.

The UNC Highway Safety Research Center (Center) is concerned that children are prematurely moving to seat belt use. According to information from the Center, the safest option for children between 40 and 60 pounds is the booster seat. In recent child restraint surveys conducted by the Center, results showed that among restrained children weighing 40 to 60 pounds, only 16% were in booster seats. More than half of the children this size were wearing seat belts. Many of the children were wearing the seat belts incorrectly, which is not only uncomfortable for the child but also unsafe.

Research by the Partners for Child Passenger Safety shows that a belt positioning booster seat can reduce a child's risk of injury by 59%.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 4

HOUSE BILL 1256

Committee Substitute Favorable 5/22/03
Committee Substitute #2 Favorable 7/8/03
Fourth Edition Engrossed 7/15/03

Short Title: Voluntary DNA Database. (Public)

Sponsors:

Referred to:

April 24, 2003

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ESTABLISH A DNA DATABANK FOR THE VOLUNTARY SUBMISSION BY INDIVIDUALS OF DNA SAMPLES LINKED WITH THE INDIVIDUAL'S MEDICAL RECORD.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 143B of the General Statutes is amended by adding the following new Part to read:

"Part 34. Voluntary DNA/Medical Records Database.

"**§ 143B-216.68. Voluntary DNA Database established; purpose.**

(a) The Secretary shall establish the Voluntary DNA Database for the recording of DNA data and related medical records submitted voluntarily by individuals for the purposes authorized in this Part. DNA data and related medical records stored in the database shall be stripped of all information that would personally identify the individual submitting the data. The Secretary may maintain the database in the Department or another suitable location. The Secretary shall appoint the Director of the DNA database who shall be responsible for marketing the database to potential donors and companies that may wish to access the database. The Secretary shall select a public research institution to develop, implement, and maintain the database.

(b) The DNA database must be capable of classifying, matching, and storing the results of analyses of DNA and other biological molecules.

(c) The DNA database may contain DNA records and related medical records of individuals who have volunteered to provide the DNA sample and medical records. The Secretary may receive, analyze, store, and destroy a record, blood sample, or other specimen for the purposes described in subsection (d) of this section.

(d) The principal purpose of the Voluntary DNA Database is to advance scientific study of the links between genetics and common diseases in order to improve

diagnosis and treatment of the diseases, provided that DNA samples and related medical records may only be stored in the database if all personal identifying information is removed. The information contained in the database may not be collected, analyzed, or stored to obtain information about human physical traits or predisposition for disease unless the purpose for obtaining the information is authorized by this subsection.

(e) The Director may publish educational materials on the Voluntary DNA Database for dissemination to the general public. The materials shall describe the purposes for which data in the database will be used, who will have access to the database, the confidential nature of samples in the database, and other information.

"**§ 143B-216.69. Collection of DNA samples.**

(a) The Secretary shall adopt rules establishing procedures in accordance with this Part for the collection, preservation, analysis, and use of blood samples or other specimens in a manner that permits the exchange of DNA samples between DNA laboratories and the use of the data for the purposes authorized under this section.

(b) The Director of the DNA database may contract with a laboratory, other State agency, private entity, or institution of higher education for services to perform DNA analyses.

(c) The DNA database may not accept a blood sample taken from a person that is submitted voluntarily unless the sample is collected in a medically approved manner by a physician or registered nurse or other person who is trained to properly collect samples or other specimens and supervised by a licensed physician. A person collecting a blood sample or other sample or specimen under this section shall not be liable in any civil action if the person collects the sample or other specimen in a reasonable manner according to generally accepted medical or other professional practices. A person voluntarily submitting hair or saliva samples or specimens, or other samples or specimens except for blood, may send the hair, saliva, or sample or specimen other than blood directly to the research institution.

(d) The Director shall provide at no cost to the individual the specimen vials, mailing tubes and labels, report forms, and other instructions for collection of blood samples or other specimens from individuals voluntarily submitting DNA to the database.

(e) A person who collects a blood sample or other specimen under this section shall send the sample or specimen to the DNA database in accordance with instructions provided by the Director.

(f) A DNA laboratory may analyze a blood sample collected under this section or other DNA specimen only for the purposes authorized under this section.

"**§ 143B-216.70. Data collection.**

(a) The Director of the DNA database shall make available on the Internet or by mail a medical history questionnaire that shall be required as part of every voluntary submission to the database. Upon receipt of the completed questionnaire from the donor, the Department shall provide for a donor test kit to be mailed to the donor. The test kit, returned samples or specimens, and the completed questionnaire will be linked and uniquely identified by a bar code or other unique number in order to preserve the donor's anonymity. When a sample is mailed to the lab site for housing, the sample will

be transferred to a stain card for storage before any analysis of the sample is undertaken. The transfer to a stain card shall be in a manner and time period that preserves the integrity of the sample for future testing. The medical history questionnaire shall be developed by the Director, in consultation with the following persons, or their designees:

(1) The Director of the Genomic Science Program, North Carolina State University.

(2) The Chair of the Department of Genetics, University of North Carolina School of Medicine.

(3) The Director of the Biomedical/Biotechnology Research Institute, North Carolina Central University.

(4) The Chair of the Department of Pediatrics/Genetics, East Carolina University School of Medicine.

(5) The Director of the Genomic Science Program, Western Carolina University.

(b) The completed medical questionnaire shall be maintained in the database. After not fewer than one thousand samples have been collected, a medical marker DNA test shall be performed, computerized, and attached to the original completed medical questionnaire. Information from the completed medical questionnaire and the medical marker test shall be linked using the unique bar code or identifying number assigned. The Department may make available the information from each linked marker and questionnaire to North Carolina based biotechnology companies and research institutions.

"**§ 143B-216.71. Access to Voluntary DNA Database information.**

(a) The Secretary shall adopt rules:

(1) To prevent unauthorized access to the DNA database.

(2) To release DNA records, specimens, or analyses from the DNA database for authorized purposes.

(3) Relating to the internal disclosure, access, or use of a sample, specimen, or DNA record in the Department of Health and Human Services DNA laboratory.

(b) A DNA sample, analysis, or record, may be released only if personally identifiable information is removed, for:

(1) A population statistics database.

(2) Identification research and protocol development.

(3) Quality control.

(c) The Director may release a record of the number of requests made for a DNA record and the name of the requesting person. The Director shall maintain a record of requests made under this section.

"**§ 143B-216.72. Confidentiality of DNA records.**

(a) A DNA record stored in the Voluntary DNA Database is confidential and is not subject to disclosure except for the purposes authorized in this Part.

(b) A person who knowingly discloses information in a DNA record or information related to a DNA analysis of a blood specimen except as authorized by this Part is guilty of a Class 1 misdemeanor.

(c) A violation of this section constitutes official misconduct.

"**§ 143B-216.73. Segregation of records.**

The Secretary shall adopt rules providing for the segregation of DNA records created under this Part from records created under Article 13 of Chapter 15A of the General Statutes.

"**§ 143B-216.74. Fees; other funds.**

The Director shall charge to participating North Carolina-based biotechnology corporations and research institutions an equal portion of the cost to store and retrieve information in the database. The annual fee for each biotechnology corporation or research institution shall be twenty-five thousand dollars ($25,000) for the first year of operating the database. After the first year, the fee shall be adjusted based on the actual cost of maintaining the system. The Department of Health and Human Services, on behalf of the Voluntary DNA Database, may accept grants, contributions, devises, bequests, and gifts, which shall be kept in a separate fund, which shall be nonreverting, and shall be used to fund the implementation and continuing operation of the Voluntary DNA Database. The Department may also accept donations of equipment and storage facilities from a State, private, or public research institution to be used for the purposes of the DNA Database.

"**§ 143B-216.75. Definitions.**

As used in this Part, unless the context clearly requires otherwise:

(1) 'Database' or 'DNA database' means the Voluntary DNA Database established under this Part for the recording of DNA samples and related medical records voluntarily submitted by an individual.

(2) 'Department' means the Department of Health and Human Services.

(3) 'Director' means the Director of the Voluntary DNA Database established under this Part.

(4) 'DNA' means deoxyribonucleic acid.

(5) 'DNA record' means DNA identification information stored in the Voluntary DNA Database for the purposes stated in this Part.

(6) 'DNA sample' means a blood sample or other specimen voluntarily submitted to the database by an individual.

(7) 'Medical record' means the questionnaire completed and submitted by the individual volunteering to participate in the database.

(8) 'Secretary' means the Secretary of Health and Human Services."

SECTION 2.(a) No funds from the General Fund shall be used to implement this act. The Secretary of Health and Human Services shall ensure that start-up and maintenance of the Voluntary DNA Database shall proceed only as authorized funds become available for these purposes.

SECTION 2.(b) This act becomes effective October 1, 2003.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 1256

Committee Substitute Favorable 5/22/03
Committee Substitute #2 Favorable 7/8/03
Fourth Edition Engrossed 7/15/03
PROPOSED SENATE COMMITTEE SUBSTITUTE H1256-CSSP-17 [v.3]

5/24/2004 4:25:07 PM

Short Title: Voluntary DNA Database. (Public)

Sponsors:

Referred to:

April 24, 2003

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE CHANCELLOR OF NORTH CAROLINA CENTRAL UNIVERSITY TO ESTABLISH A DNA DATABASE FOR THE VOLUNTARY SUBMISSION BY INDIVIDUALS OF DNA SAMPLES LINKED WITH THE INDIVIDUAL'S MEDICAL RECORD.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 116 of the General Statutes is amended by adding a new Article to read:

"Article 33.
Voluntary DNA/Medical Records Database.

"**§ 116-261. Definitions.**

As used in this Part, unless the context clearly requires otherwise:

(1) 'Database' or 'DNA Database' means the Voluntary DNA Database established under this Part for the recording of DNA samples and related medical records voluntarily submitted by an individual.

(2) 'Director' means the Director of the Voluntary DNA Database established under this Part.

(3) 'DNA' means deoxyribonucleic acid.

(4) 'DNA record' means DNA identification information stored in the Voluntary DNA Database for the purposes stated in this Part.

(5) 'DNA sample' means a blood sample or other specimen, including hair or saliva, voluntarily submitted to the DNA Database by an individual.

(6) 'Medical record' means the questionnaire completed and submitted by an individual who volunteers to participate in the DNA Database.

(7) 'Chancellor' means the Chancellor of North Carolina Central University."

"**§ 116-262. Voluntary DNA Database established; purpose.**

(a) The Chancellor shall establish the Voluntary DNA Database to record DNA data and related medical records submitted voluntarily by individuals for the purposes authorized in this Part. DNA data and related medical records stored in the database shall be stripped of all information that would personally identify the individual submitting the data.

(b) The Chancellor shall appoint the Director of the DNA Database who shall oversee all operations related to the database.

(c) The Director shall ensure that the database can classify, match, and store the results of analyses of DNA and other biological molecules.

(d) The Director shall ensure that the database is capable of storing DNA records and related medical records of individuals who have volunteered to provide the DNA sample and medical records.

(e) The Director shall ensure that the DNA Database has the capacity to receive, analyze, store, or destroy a record, blood sample, or other DNA sample only for the purposes described in subsection (f) of this section.

(f) The principal purpose of the DNA Database is to advance scientific study of the links between genetics and common diseases in order to improve diagnosis and treatment of the diseases. The information contained in the database shall not be collected, analyzed, or stored to obtain information about human physical traits or predisposition for disease unless the purpose for obtaining the information is authorized by this section.

(g) The Director may publish educational materials on the Voluntary DNA Database for dissemination to the general public. The materials shall describe the purposes for which data in the database will be used, who will have access to the database, the confidential nature of samples in the database, and other relevant information.

"**§ 116-263. Collection of DNA samples.**

(a) The Director shall establish procedures in accordance with this Part for the collection, preservation, analysis, and use of blood samples and other DNA samples in a manner that permits the exchange of DNA samples between the DNA Database and the use of the data for the purposes authorized under this Part.

(b) The Director may contract with a laboratory, State agency, private entity, or institution of higher education for services to perform DNA analyses.

(c) The Director or the Director's designee shall only accept blood samples that are collected in a medically approved manner by a physician or registered nurse or other person who is trained to properly collect blood samples and supervised by a licensed physician.

(d) A person collecting a blood sample under this section shall not be liable in any civil action if the person collects the sample or other DNA sample in a reasonable manner according to generally accepted medical or other professional practices.

(e) A person may submit a DNA sample, other than blood, directly to the DNA database.

(f) The Director or the Director's designee shall provide at no cost to the individual specimen vials, mailing tubes, labels, report forms, and other instructions for collection of blood samples or other DNA samples submitted to the DNA Database.

(g) A person who collects a blood sample or other DNA sample under this section shall submit the sample to the DNA Database in accordance with instructions provided by the Director.

(h) A DNA laboratory may analyze a DNA sample only for the purposes authorized under this Part.

"**§ 116-264. Data collection.**

(a) The Director or the Director's designee shall make available on the Internet or by mail a medical history questionnaire that shall be required as part of every voluntary submission to the database. The medical history questionnaire shall be developed by the Director, in consultation with the following persons, or their designees:

(1) The Director of the Genomic Science Program, North Carolina State University.

(2) The Chair of the Department of Genetics, University of North Carolina School of Medicine.

(3) The Director of the Biomedical/Biotechnology Research Institute, North Carolina Central University.

(4) The Chair of the Department of Pediatrics/Genetics, East Carolina University School of Medicine.

(5) The Director of the Genomic Science Program, Western Carolina University.

(b) Upon receipt of the completed questionnaire from the donor, the Director or the Director's designee shall provide for a donor test kit to be mailed to the donor. The test kit, DNA samples, and the completed questionnaire shall be linked and uniquely identified by a bar code or other unique number in order to preserve the donor's anonymity. When a DNA sample is received by the DNA Database, the sample shall be transferred to a stain card for storage before any analysis of the sample is undertaken. The DNA Database shall perform the transfer to a stain card to preserve the integrity of the sample for future testing.

(c) Medical questionnaires shall be maintained in the DNA Database. After not fewer than one thousand samples have been collected, medical marker DNA tests shall be performed, computerized, and attached to the original completed medical questionnaires. The Director or the Director's designee may provide the information from each marker and questionnaire to North Carolina based biotechnology companies and research institutions.

"**§ 116-265. Access to Voluntary DNA Database information.**

(a) The Director shall establish guidelines:

(1) To prevent unauthorized access to the DNA Database.

(2) To release DNA records, DNA samples, or analyses from the DNA Database for authorized purposes.

(3) Relating to the internal disclosure, access, or use of a DNA sample, or DNA record by the DNA Database.

(b) Anonymous DNA samples, analyses, or records may be released for:

(1) A population statistics database.

(2) Identification research and protocol development.

(3) Quality control.

(c) The Director or the Director's designee may release a record of the number of requests made for a DNA record and names of persons who made the requests. The Director or the Director's designee shall maintain a record of requests made under this section."

"**§ 116-266. Confidentiality of DNA records.**

(a) A DNA record stored in the Voluntary DNA Database is confidential and is not subject to disclosure except for the purposes authorized in this Part.

(b) A person who knowingly discloses information in a DNA record or information related to a DNA analysis of a blood sample except as authorized by this Part is guilty of a Class 1 misdemeanor."

"**§ 116-267. Segregation of records.**

The Director shall establish guidelines providing for the segregation of DNA records created under this Part from records created under Article 13 of Chapter 15A of the General Statutes."

"**§ 116-268. Fees; other funds.**

The Chancellor or the Chancellor's designee shall charge to participating North Carolina-based biotechnology corporations and research institutions an equal portion of the cost to store and retrieve information in the database. The annual fee for each biotechnology corporation or research institution shall be twenty-five thousand dollars ($25,000) for the first year of operating the database. After the first year, the fee shall be adjusted based on the actual cost of maintaining the system. North Carolina Central University, on behalf of the Voluntary DNA Database, may accept grants, contributions, devises, bequests, and gifts, which shall be kept in a separate fund, which shall be nonreverting, and shall be used to fund the implementation and continuing operation of the Voluntary DNA Database. The Chancellor may also accept donations of equipment and storage facilities from a State, private, or public research institution to be used for the purposes of the DNA Database.

SECTION 2.(a) No funds from the General Fund shall be used to implement this act. The Chancellor shall ensure that start up and maintenance of the Voluntary DNA Database shall proceed only as authorized funds become available for these purposes.

SECTION 2.(b) This act becomes effective December 1, 2004, and applies to offenses committed on or after that date.

HOUSE BILL 1256:
Voluntary DNA Database

BILL ANALYSIS

Committee:	Senate Health and Human Services	**Introduced by:**	Reps. Miller & Walend
		Summary by:	Sandra Alley Committee Counsel
Date:	May 24, 2004		
Version:	H1256-CSSP-17 [v.3]		

SUMMARY: ***House Bill 1256 directs the Chancellor of North Carolina Central University to establish a DNA database for the recording of DNA data and related medical records submitted voluntarily by participants, for the purpose of advancing scientific study of the links between genetics and common diseases.***

BILL ANALYSIS: **Section 1** of the bill directs the Chancellor of North Carolina Central University to establish a DNA database for the recording of DNA data and related medical records submitted voluntarily by individuals.

Under the bill, the Chancellor would establish the database at the University, and would appoint a person to serve as Director of the database. The Director would oversee the day to day operations of the DNA Database and would be authorized to publish and disseminate educational materials on the database, describing the purposes for which the data will be used, and describing the confidential nature of samples in the database.

The principal purpose of the DNA Database is to advance scientific study of the links between genetics and common diseases in order to improve diagnosis and treatment of the diseases. All DNA data and related medical records stored in the database would be stripped of any information that would personally identify the individual submitting the data.

The Director of the database would be authorized to conduct DNA analyses or to contract with a laboratory, other State agency, private entity or other institution of higher education for services to perform DNA analyses. The Director would be authorized to receive, analyze, store, or destroy a medical record, blood sample, or other DNA sample. The Director will provide at no cost to the individual the necessary instructions along with specimen vials, ailing tubes and labels, and report forms.

Blood samples submitted to the database must be collected in a medically approved manner by a physician, nurse, or other properly trained person supervised by a licensed physician.

The Director would be required to establish guidelines that would prevent the unauthorized access to the DNA database, and to provide for the release of information from the database for authorized purposes.

A DNA record stored in the database would be confidential and would not be subject to disclosure except for authorized purposes; any person who knowingly discloses information in a DNA record or information related to a DNA analysis of a blood specimen except as authorized would be guilty of a Class 1 misdemeanor. DNA records in the Voluntary Database shall be kept separate from records created under the Criminal Procedure Act.

The Director of the database would be authorized to collect a reasonable fee for providing population statistics data or other research data, and may charge to North Carolina-based biotechnology corporations and research institutions an equal portion of the cost to store and retrieve information in the database. The annual fee for each biotechnology corporation or research institution is $25,000 for the first year of operating the database. Thereafter, the charge would be based on a formula that takes into account the actual cost of maintaining the system and the number of biotechnology corporations and research institutions in the State.

BACKGROUND: Deoxyribonucleic Acid (DNA) is the carrier of the genetic code for living organisms. In other words, it contains the blueprint for how humans, and other organisms, work. Advances in medicine, genetics, and forensic science can be attributed to the research done on DNA. Many research institutions and biotechnology companies use DNA research to search for new treatments and cures for various diseases and medical conditions. For example, UNC-Chapel Hill recently announced a new voluntary DNA registry in conjunction with the National Institute of Environmental Health Sciences (NIEHS) to study relationships among environmental exposures, genetic susceptibility and human disease.

Effective Date: This bill would become effective December 1, 2004 and the criminal penalties in it would apply to offenses on or after that date.

Discoverer backs DNA databanks

posted Thursday May 15, 2003
From The [Raleigh] News & Observer

Thursday, May 15, 2003 6:02AM EDT

By ANNE BLYTHE AND DAN KANE, Staff Writers

CHAPEL HILL -- James Watson, who 50 years ago co-discovered the double helix structure of DNA, was thinking more about getting a decent job and a devoted woman than the lasting effect of his scientific triumph.

The brash, young American biologist never dreamed that five decades later, state legislators in Raleigh would be talking about expanding a DNA databank used by law-enforcement officers in criminal investigations and creating one for researchers trying to uncover the genetic causes of disease.

"My thoughts were 'If this is correct, I'll get a good job and find me a girlfriend,' " Watson said. "You know, I was 24."

The Nobel laureate, married, somewhat stooped, balding and white-haired now, was in Chapel Hill on Wednesday for the opening at the Morehead Planetarium and Science Center of "DNA: The Secret of Life," a project designed to mark the 50th anniversary of the double helix discovery. As he fielded questions from reporters, inquisitive high school students, Chancellor James Moeser of UNC-Chapel Hill and others involved with the premier event, legislators in the Capital City were hoping for a eureka moment of their own.

Political, privacy issues

Rep. Paul Miller, a Durham Democrat, knows the hit-or-miss nature of scientific discovery firsthand. When his newborn niece was diagnosed with liver cancer, doctors used a regimen of drugs that did not exist a year earlier and were dropped a year later because they did not work for others.

"If she had come into that cancer program a year earlier or a year later, she wouldn't have gotten the [treatment], and she would have died," Miller said.

That's one reason he has sponsored three bills that would create a state-managed DNA research databank with tens of thousands of samples from inmates and volunteers -- a font of information that genetic researchers could use in trying to solve some of medicine's most confounding mysteries.

"Anything we can do to enhance DNA research will be a big plus for North Carolina, especially with the biotechnology industry we have here," Miller said.

But he and the three genomic researchers from N.C. Central University and UNC-CH whom Miller brought to the House Science and Technology Committee on Wednesday acknowledge the big political hurdles ahead for the project, estimated to cost $600,000 at the outset. The idea is to create a databank that would protect the privacy of those who provide samples, while collecting enough medical history information for researchers trying to figure out how genes trigger disease.

There are concerns also about the quality of the data. Dr. James P. Evans, UNC-CH director for Genetics Cancer Services, told legislators that a databank filled only with DNA from inmates would be skewed. "If North Carolina does this right, it could be a leader and a great example of how to harness the burgeoning field of genetics for the general good," Evans said before the meeting. "If we do it wrong, it could be very ugly."

Biotechnology companies and research institutions would pay a $25,000 annual fee to access the data in the first year; in subsequent years, their fee would be determined by splitting the annual operating cost among the users. As proposed, misuse of the data would be a misdemeanor.

'Red flags jump up'

The meeting Wednesday, the first hearing on the legislation, drew questions about cloning that have little to do with the databank but could scare off support. "That's why we have to have these discussions," Miller said. "When we jump from DNA to cloning, all these red flags jump up."

These are questions that Watson gets regularly on his speaking tour.

On the Chapel Hill campus, nearly 30 miles from the state legislative debate, the first question Watson faced from a roomful of nearly 100 high school students was about cloning.

"It's not one of my real worries," Watson said with a grin. "I hope it can't be done. I think it would confuse the legal system. ... I think we all know people who we wouldn't want cloned. You're the age, I guess, of people who should be worried about it. I'm worried about nuclear weapons being used in New York. I'm worried about Alzheimer's [disease], I guess. But I'm not worried about cloning."

Although a man dogged through the decades by his sometimes-outlandish off-the-cuff remarks, Watson is not one to shy away from controversies over the use of DNA. He is miffed, he says, that laws do not yet prevent genetic discrimination with information that DNA sequencing provides. But he's all for databanks designed to further scientific research.

"I think if you don't do it, America will lose out," Watson said Wednesday. "Obviously you want to keep the data secret -- by secret, I mean everyone should have control over your own DNA."

As he made his whirlwind trip through Chapel Hill, Watson talked about the medical secrets that he hoped would be unlocked by the discovery he and Francis Crick made five decades ago in the famed Cavendish lab at Cambridge University in England.

He willingly talked about the recent feminist controversy over how little credit the men gave to Rosalind Franklin, the chemist whose research provided a key clue in their cracking of the case many scientists were trying to solve. "The truth is she should have solved the problem a year before we did, but she made some mistakes," he said. "She wanted to do something and feel she'd done it on her own. Francis and I just wanted the answer."

That answer is the subject of the 33-minute production of "DNA: The Secret of Life," a collaboration that UNC-CH helped fund that will be distributed worldwide to other museums and science centers by the Morehead Planetarium and Science Center. Watson likes the project, and Holden Thorp, the Morehead center director and a chemist, is proud to have him on board.

"Jim Watson is, I think, the most famous living scientist," Thorp said.

Staff writer Anne Blythe can be reached at 932-8741 or ablythe@newsobserver.com.

Photo by Shawn Rocco for the N&o

A DATABASE OF DNA

Scientists at Carolina and the National Institute of Environmental Health Sciences (NIEHS) will recruit about 20,000 patients at various Carolina medical facilities for a voluntary DNA registry. The "environmental polymorphism registry" (EPR) will help researchers investigate the relationships among environmental exposures, genetic susceptibility, and human disease. Genetic susceptibility and environmental exposures play roles in various diseases including Parkinson's disease, lung cancer, and even atopy — the genetic tendency to develop allergic diseases such as allergic rhinitis (hay fever), atopic dermatitis, and asthma.

The database will code all identifiers to maintain patient confidentiality, as have previous similar registries. But the EPR maintains the link between the code and the patient identifiers, making it possible for scientists to contact the participants later for permission to include their DNA in other studies. Such studies, including the process of identifying participants, will require approval of an oversight committee and Institutional Review Boards that protect the rights of research subjects. Participation in studies will be strictly voluntary, and anyone can drop out of the registry at any time.

The scientists conducted a pilot study involving an estimated 600 people at UNC-Chapel Hill's Ambulatory Care Clinic to determine the feasibility of putting the registry together. About 80 percent consented to allow a portion of a blood sample drawn for other medical purposes to be used for DNA isolation and for addition to the registry depository for twenty-five years.

Perry Blackshear, NIEHS director of clinical research, and Patricia Chulada, health science administrator at NIEHS, initiated the registry by approaching Carolina researchers Paul Watkins, professor of medicine and director of the Caviness General Clinical Research Center (GCRC), and Susan Pusek, GCRC director of training and career development. UNC-Chapel Hill's major role in the database is to provide access to its huge patient population. Once patients have been recruited, NIEHS will take direct charge of the follow-up studies on genetic variations of patients' DNA. But Watkins and Pusek will remain key players as members of the steering committee.

The data from the follow-up studies will help scientists identify groups of people with genetic polymorphisms — variations in DNA — in "environmentally sensitive" genes. These genes regulate the body's interactions with environmental factors, encoding proteins that control a wide variety of cellular functions. For instance, due to genetic variations, not all cigarette smokers will develop lung cancer. Another example — the Japanese are known to have a low incidence of cancer, but some Japanese, on switching to an American diet, have developed cancer. So, the environment affects different people in different ways, one of the major factors being the genetic makeup of individuals.

"The data collected from these studies may be used to define environmental risk factors and develop preventive strategies to reduce the incidence of disease," Blackshear says. Watkins says, "Creation of this registry will keep UNC-Chapel Hill at the cutting edge of environmental health research in the decades ahead." ::e

— by Vidhya V. Iyer

back to contents

All text and images copyright © 2004 **Endeavors** magazine at the **University of North Carolina at Chapel Hill**.
All rights reserved.

VISITOR REGISTRATION SHEET

Senate Committee on Health & Human Resources May 26, 2004

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Mari Lentz	GSK
Lu-Ann Coe	NCPA
John Cyrus	NC State Grange
Evelyn Hawthorne	EHGR
Sheila McKinney	NC DHHS
Jamie Ramstad	NC IMS
Sara Schmidt	NC Justice Center + Common
John McMillan	MFDS
Shane Hartzell	AP
C.J. Williams	UNC-TV (the Leg)
FRANK W. FOLGER	NCDOT

VISITOR REGISTRATION SHEET

Senate Committee on Health & Human Resources May 26, 2004

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Leonard	WCSR
Luke Crotty	Gov Office
John McHugh	Gov office
Joe Delk	Gov. Office
Lauren Mims	GHSP
Nancy Reed	SCCF
Adrian Lovelace	MHA-NC
Dana Simpson	Smith Anderson
ANNE LOFLIN	DHHS
Adam Prudence	NCASA
Roy Sawyer	NCCCC
Sally Cameron	NCPA

VISITOR REGISTRATION SHEET

Senate Committee on Health & Human Resources May 26, 2004

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Steve Shore	NC Pediatric Society
VINAY BHATIA	NC CHILD ADVOCACY INSTITUTE
AL DEITCH	DOA PAID
TOM VITAGLIONE	NC CHILD ADVOCACY INST.
BILL HALL	UNC Highway Safety Research Center
Kim Conyers	State Farm Ins Co.
DAVID STOLLER	STATE FARM
Elizabeth Dalton	Bone Assoc.
Barbara Canales	MFSS
Joanne Stevens	NCNA
DAVID BARNES	Poyner & Spruill LLP
Robert Paschal	Young, Moore
Steve Mitchell	NOVARTIS

JOHN GOODMAN

Wayne Kam

GARY SACAMIDO

Kam

ALLEY ASSOCIATES

Stuff

GSK

NCACDS

NC CFTF

Lorraine Blake (Sen. Purcell)

From: Judy Chriscoe (Sen. Bingham)
Sent: Tuesday, June 01, 2004 2:44 PM
To: Sen. A.B. Swindell; Rep. Martha Alexander; Rep. John I. Sauls; Rep. Verla Insko
Subject: CORRECTED NOTICE - June 2, 2004, Health and Human Resources Meeting

Principal Clerk _____
Reading Clerk _____

Corrected: Add a Bill - HB1356

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health & Human Resources** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 2, 2004	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 1148	Care for the Mentally Ill in LTC Facilities.	Senator Swindell
HB 1356	Increase Fees/Qualifs. for DWI Assessments.	Representative Sauls Representative Alexander Representative Insko

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

AGENDA

SENATE HEALTH & HUMAN RESOURCES COMMITTEE
Wednesday, June 2, 2004 at 11:00 AM
Room 544, LOB

I. Welcome and Opening Remarks

II. Bills to be Considered

BILL NO.	SHORT TITLE	SPONSOR
• SB 1148	Care for the Mentally Ill in LTC Facilities	Senator Swindell
• HB 1356	Increase Fees/Qualifs. For DWI Assessments	Representative Alexander Representative Insko Representative Sauls

II. Other Business

IV. Adjournment

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 2, 2004 at 11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, June 2, 2004 in Room 544 of the Legislative Office Building. Eleven members were present. Senator Stan Bingham and Senator William R. Purcell, Co-Chair, welcomed the committee members present and introduced the pages.

Senator Bingham introduced Senator A. B. Swindell, IV to present, *SB 1148, Care for the Mentally Ill in LTC Facilities*, to the Committee. Senator Swindell stated this bill was from The Commission On Aging and that it requires The Department of Health and Human Services to bolster their efforts in providing assistance to long term care facilities serving mentally ill residences. The bill requires the department to study the expanding mission of geriatrics mental health specialty teams. The upshot of this comes from The Olmstead Act where they are trying to take folks out of different facilities and put them back in other facilities such as nursing homes or care facilities. The teams are now going through out the state. This is a study bill. Senator Purcell offered an amendment, which moved to amend the bill on page l, line 14, by inserting "immediately" between the words "proceed" and "with". Dianne Jessup explained that there was a concern wanting the undertaking in section two to proceed immediately. Senator Allran encouraged support of the amendment. Senator Dannely asked for a favorable report. Senator Bingham asked for a vote on the amendment, which carried. The amendment was rolled into a Committee Substitute Bill. The vote was taken, unfavorable as to bill, but favorable as to the committee substitute, which passed unanimously. Senator Kinnaird had a question stating she knew it was a study but wanted to know if they were trying to establish residency that were just for older mentally ill people or were they going to be threaded in the run of the mill long term care facilities. Sen. Swindell responded they will be a part of the long term care facilities out there now and where the problem lies is; there is not a model of what to do from county to county. The team will work with the counties to establish what care should be provided which will become a standard from DHHS. Sen. Kinnaird had a follow up question stating there is a problem with long-term care aids. The pay is low and there is a high turn over. Will there be added special training for these aids that will be caring for the mentally ill or will there be another level of aids with more training. Dianna Jessup responded that part of the purpose of these teams were to provide technical assistant to these special need. Sen. Allran asked the Chairman to see if someone in the audience would like to express thoughts on putting mental ill patients into exiting nursing home where people are not mentally ill. John Tote, Executive Director of The Mental Health Association in NC, stated that clearly this has been an issue that they have been concerned about for years, not just when the Olmsted Case came out of the federal level. With the institutions downsizing this is going to place a heavier burden on the long term care industry, in addition to our communities, as the area programs turn into local management entities. Senator Forrestry asked where and what the twenty specialty teams do and where they are stationed. Lou Wilson, NC Association of Long Term Care Facilities responded that the geriatric specialty teams were established by the department and went to work in July 2003. Each of the area programs has been instructed to have a team or contract a team. They assist the provider with the type of training their staff needs.

Senator Bingham recognized Representative Martha Alexander to explain *HB 1356, Increase Fees/Qualifications For DWI Assessments*. Rep. Alexander stated the bill comes as a recommendation of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. They appointed a DWI advisory committee to do a thorough study of DWI Assessments. The bill increases the minimum qualification of individuals conducting an assessment, in private and public places. The bill will increase the fee to $100.00, from $25.00 established back in 1983, which was raised in 1988 to $50.00. The bill also directs the oversight committee to study certification requirements of persons conducting Alcohol and Drug Education Traffic Schools, and to study the fee paid by DWI offenders for education or treatment services. This bill has gone through the House Finance Committee without any amendments and is still in version one. Senator Bingham stated this bill would automatically go to the Senate Finance Committee. Senator Dannely moved for a favorable report. Senator Forrestor asked what will happen if the DWI offender does not have the money to pay. Jason Reynold from the Department stated that right now the assessment fee of $50.00 is required regardless of the ability to pay. With passage of this bill the treatment cost that is above $75.00 will be on a sliding fee scale. So they will have to pay the current $50.00 assessment fee and the first $75.00 of treatment. The vote was taken with no opposition.

The meeting adjourned at 11:50 A.M.

Senator Stan Bingham

Senator William R. Purcell, Co-Chair

Judy Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 02, 2004

Senator BINGHAM,
submits the following with recommendations as to passage:

FAVORABLE

H.B. **1356** Increase Fees/Qualifs. for DWI Assessments.
Sequential Referral: Finance
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **1148** Care for the Mentally Ill in LTC Facilities.
Draft Number: PCS65451
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 1148

Short Title:	Care for the Mentally Ill in LTC Facilities.	(Public)
Sponsors:	Senators Swindell, Allran, Dannelly, Moore, Queen; Bingham, Dalton, Hargett, Holloman, Kerr, Kinnaird, Lucas, Malone, and Purcell.	
Referred to:	Health & Human Resources.	

May 18, 2004

A BILL TO BE ENTITLED

AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study expanding the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. As part of this study, the Department shall consider renaming the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

SECTION 2. While undertaking the study, the Department of Health and Human Services shall proceed with implementation of the following:

(1) Standardizing these criteria across all Geriatric Mental Health Specialty Teams:
   a. Team purpose,
   b. Eligibility for services,
   c. Screening processes,
   d. Referral processes, and
   e. Forms, Training Manuals, Service Orders, and Authorizations.

(2) Tracking expenditure data for each Team and each Area Program/Local Management Entity.

(3) Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team.

SECTION 3. The Department of Health and Human Services shall submit an interim report to the North Carolina Study Commission on Aging by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number

of facilities served, clients served, and services provided by each Team. The Department shall submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging by October 30, 2005.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S D

SENATE BILL 1148
PROPOSED COMMITTEE SUBSTITUTE S1148-PCS65451-SQ-1

Short Title: Care for the Mentally Ill in LTC Facilities. (Public)

Sponsors:

Referred to:

May 18, 2004

A BILL TO BE ENTITLED

AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study expanding the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. As part of this study, the Department shall consider renaming the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

SECTION 2. While undertaking the study, the Department of Health and Human Services shall proceed immediately with implementation of the following:

(1) Standardizing these criteria across all Geriatric Mental Health Specialty Teams:
   a. Team purpose,
   b. Eligibility for services,
   c. Screening processes,
   d. Referral processes, and
   e. Forms, Training Manuals, Service Orders, and Authorizations.

(2) Tracking expenditure data for each Team and each Area Program/Local Management Entity.

(3) Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team.

SECTION 3. The Department of Health and Human Services shall submit an interim report to the North Carolina Study Commission on Aging by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number

of facilities served, clients served, and services provided by each Team. The Department shall submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging by October 30, 2005.

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

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 1

H. B. No. _____ DATE 6/2/04

S. B. No. 1148 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
Sen.) _____

1 moves to amend the bill on page 1, line 14
2 ( ) WHICH CHANGES THE TITLE
3 by inserting "immediately" between the words
4 "proceed" and "with".
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19

SIGNED William N Pell

ADOPTED ✓ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

SENATE BILL 1148:
Care for the Mentally Ill in LTC Facilities

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Senator Swindell
		Summary by:	Theresa Matula Commission on Aging Staff
Date:	June 2, 2004		
Version:	First Edition		

SUMMARY: Senate Bill 1148 requires the Department of Health and Human Services to provide additional support and training for long-term care providers caring for residents with mental illnesses. This bill represents a recommendation from the North Carolina Study Commission on Aging. The bill would become effective when it becomes law.

REFERENCE INFORMATION:

G.S. 122C-102 requires the Department of Health and Human Services to develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. Consistent with the Supreme Court decision in Olmstead vs. L.C. & E.W, the State's policy is to provide appropriate services to clients in the least restrictive and most appropriate environment. The long-term care residents referenced in Senate Bill 1148 are those targeted populations identified in the State Plan.

BILL ANALYSIS:

Senate Bill 1148 requires the Department of Health and Human Services to bolster their efforts in providing assistance to long-term care facilities serving mentally ill residents.

The bill requires the Department to study expanding the mission of the Geriatric Mental Health Specialty Teams, and to consider renaming the Geriatric Mental Health Specialty Teams to the LTC Mental Health Specialty Teams (to reflect the expanded mission).

The bill also requires the Department, while undertaking the study, to standardize criteria across all Geriatric Mental Health Specialty Teams; to track expenditure data for each Team and each Area Program/Local Management Entity; and to track the number of facilities served, the number of clients served, and the types of services provided by each Team.

The Department is required to submit to the North Carolina Study Commission on Aging, an interim report by October 30, 2004, and a final report by October 30,2005.

BACKGROUND:

In the report to the Governor and the 2004 Regular Session of the 2003 General Assembly, the North Carolina Study Commission on Aging recommended that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

This recommendation was in response to presentations on February 10, 2004 and March 9, 2004, from the Division of Facility Services, Department of Health and Human Services (DHHS); the NC National Alliance for the Mentally Ill (NAMI); the NC Association Long Term Care Facilities; and the Community Policy Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services.

Geriatric Mental Health Specialty Teams were developed to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living in their own home or with family members. Individuals with geriatric-like needs are also served.

Long-term care providers expressed appreciation for the Geriatric Mental Health Specialty Team concept but indicated a desire for a more intensive effort and for more consistency and standardization across the Teams.

According to information provided by staff in the General Assembly's Fiscal Research Division, the Geriatric Mental Health Specialty Teams are a contracted service through the Local Management Entities (LME). There are 20 Teams across North Carolina and each one contracts with one or more LME's. These are funded with Mental Health Trust Fund dollars, and these non-recurring funds are being replaced by recurring funds made available through mental hospital downsizing. As a Team delivers services to a facility, they file for reimbursement with the LME, which in turn seeks reimbursement from DHHS. Currently, DHHS cannot report specific cost data on the Geriatric Mental Health Specialty Teams, thus the Commission believes that additional expenditure and tracking data is necessary.

S1148-SMSH-001

Geriatric Mental Health Specialty Team Model and Guidelines

Background: A need for greater local capacity to address the needs of older adults with mental illness was recognized as plans were developed to increase community capacity to serve older adults and to reduce reliance on State hospital services in SFY 02-03. At that time, funding was provided to develop twenty community-based geriatric mental health specialty teams that would be available to provide expertise and services throughout the State.

Purpose: The purpose of these teams is to increase the ability of older adults with mental illness to live successfully in their communities by:

1. assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals, and
2. providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

This is to be accomplished by providing training and consultation to the staff serving the identified individuals, developing linkages with community providers serving older individuals and providing time limited specific direct services to the identified individuals.

Team Description: The teams are to consist minimally of a registered nurse and a masters prepared therapist and are to supplement current area program/LME capacity to serve adults, age 60 and over. The teams are to provide the majority of services where the individual lives rather than in an office/clinic setting. Team duties and activities may be assigned based on each team member's professional skills and abilities. Team members may perform some activities together when the situation calls for the professional skills of more than one team member. Team members must have the ability to communicate frequently and to meet face to face as needed.

Target Population: The target population includes:

1. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, who are in a state psychiatric hospital and who are preparing to return to the community to reside in a nursing home, adult care home or family residence
2. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, currently residing in a nursing home or adult care home who have mental health service/treatment needs and who may be at risk of psychiatric hospitalization.
3. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness who have significant mental health service or treatment needs and who may be at risk of psychiatric hospitalization and who are living with in their own home or with family members.

Team Activities:
Examples of the types of activities the team may provide ***to assist with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals*** include, but are not limited to, the following:

- provide information to AP/LME and state hospital regarding strengths and capabilities of nursing homes and adult care homes for individual discharge planning;
- assist in discharge planning with hospital staff and area program/LME and referral to identified service providers that have the ability to provide specific treatments, rehabilitative services and/or residential setting that are needed by the individual.
- provide consultative support to staff in the transition of individuals from state hospital to facility;
- provide consultation with staff, individual and family identifying interventions to ensure transition to community, alleviate behaviors that may threaten placement
- providing crisis-oriented face-to-face to the individual or phone support during normal work hours and liaison with crisis services as needed to prevent hospitalization or disruption of placement

Examples of the types of activities the team may provide ***to assist nursing homes, adult care homes, and other agencies or caregivers/families*** that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization include, but are not limited to, the following:

- provide case consultation with staff, individual and family regarding behaviors that may result in hospitalization or need for more intensive services
- assist staff to assess behaviors;
- provide input and support in the development of intervention plans;
- model for staff appropriate implementation of intervention plans as needed;
- provide services such as referrals to community services, assistance with obtaining benefits, time limited case management and/or time limited treatment and support services
- review of medication regime and educate staff in communication with psychiatrist, physician and pharmacist
- educate facility staff, other agencies and families on issues on such topics as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population
- provide resource information and identify ongoing training resources for staff
- provide a session of new staff orientation on such topics as individual rights;

Note: These funded Gero Specialty Teams are <u>not</u> expected to be primarily providers of direct services such as case management, community based service (CBS) or treatment services, but may do so on a time limited basis to assist in the transition to the community or to prevent hospitalization. If the individual requires on going direct services, the team

will contact the area program/LME and request the individual be referred to a provider of such services whenever such a provider is available in the community. The Gero Specialty Team intent is not to replace needed treatment, rehabilitative or support services. These time limited direct services will be provided only for identified individuals (i.e. those who meet age and diagnostic criteria and/or have been discharged from a state hospital).

Area Program/LME responsibilities. Each of the area programs/LMEs that received State funding for a Geriatric Mental Health Specialty Team is responsible for:

- ensuring that the team, whether as an area program service or as a contracted service, provides and documents services in a way that is consistent with all Division requirements including, but not limited to, human rights, training, confidentiality, client records, and reporting
- having an identified AP/LME person who is responsible for the team's operation, if operated by the AP/LME or having a primary contact person who is responsible for communication, problem solving, prompt payment, and oversight if the team is contracted out.
- establishing an agreement about how team services will be made available to other catchment area(s) if the allocation indicated that the team is to serve more than the funded area program/LME. This agreement should specify access to service parameters including how referrals will be made to the team and expectations regarding reporting, documenting, and billing for client specific direct services.

Questions about the Geriatric Mental Health Specialty Team model and guidelines from AP/LMEs should be directed to Debbie Webster, NC Div MH/DD/SAS, Community Policy Section, Best Practice Team, 3005 Mail Service Center, Raleigh, NC 27699-3005
Phone 919 715-2774
Email Debbie.Webster@ncmail.net

SENATE BILL 1148:
Care for the Mentally Ill in LTC Facilities

BILL ANALYSIS

Committee:	Senate Health and Human Resources	**Introduced by:**	Senator Swindell
		Summary by:	Theresa Matula Commission on Aging Staff
Date:	June 2, 2004		
Version:	First Edition		

SUMMARY: ***Senate Bill 1148 requires the Department of Health and Human Services to provide additional support and training for long-term care providers caring for residents with mental illnesses. This bill represents a recommendation from the North Carolina Study Commission on Aging. The bill would become effective when it becomes law.***

REFERENCE INFORMATION:

G.S. 122C-102 requires the Department of Health and Human Services to develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. Consistent with the Supreme Court decision in Olmstead vs. L.C. & E.W, the State's policy is to provide appropriate services to clients in the least restrictive and most appropriate environment. The long-term care residents referenced in Senate Bill 1148 are those targeted populations identified in the State Plan.

BILL ANALYSIS:

Senate Bill 1148 requires the Department of Health and Human Services to bolster their efforts in providing assistance to long-term care facilities serving mentally ill residents.

The bill requires the Department to study expanding the mission of the Geriatric Mental Health Specialty Teams, and to consider renaming the Geriatric Mental Health Specialty Teams to the LTC Mental Health Specialty Teams (to reflect the expanded mission).

The bill also requires the Department, while undertaking the study, to standardize criteria across all Geriatric Mental Health Specialty Teams; to track expenditure data for each Team and each Area Program/Local Management Entity; and to track the number of facilities served, the number of clients served, and the types of services provided by each Team.

The Department is required to submit to the North Carolina Study Commission on Aging, an interim report by October 30, 2004, and a final report by October 30,2005.

BACKGROUND:

In the report to the Governor and the 2004 Regular Session of the 2003 General Assembly, the North Carolina Study Commission on Aging recommended that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

This recommendation was in response to presentations on February 10, 2004 and March 9, 2004, from the Division of Facility Services, Department of Health and Human Services (DHHS); the NC National Alliance for the Mentally Ill (NAMI); the NC Association Long Term Care Facilities; and the Community Policy Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services.

Geriatric Mental Health Specialty Teams were developed to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living in their own home or with family members. Individuals with geriatric-like needs are also served.

Long-term care providers expressed appreciation for the Geriatric Mental Health Specialty Team concept but indicated a desire for a more intensive effort and for more consistency and standardization across the Teams.

According to information provided by staff in the General Assembly's Fiscal Research Division, the Geriatric Mental Health Specialty Teams are a contracted service through the Local Management Entities (LME). There are 20 Teams across North Carolina and each one contracts with one or more LME's. These are funded with Mental Health Trust Fund dollars, and these non-recurring funds are being replaced by recurring funds made available through mental hospital downsizing. As a Team delivers services to a facility, they file for reimbursement with the LME, which in turn seeks reimbursement from DHHS. Currently, DHHS cannot report specific cost data on the Geriatric Mental Health Specialty Teams, thus the Commission believes that additional expenditure and tracking data is necessary.

S1148-SMSH-001

Geriatric Mental Health Specialty Team Model and Guidelines

Background: A need for greater local capacity to address the needs of older adults with mental illness was recognized as plans were developed to increase community capacity to serve older adults and to reduce reliance on State hospital services in SFY 02-03. At that time, funding was provided to develop twenty community-based geriatric mental health specialty teams that would be available to provide expertise and services throughout the State.

Purpose: The purpose of these teams is to increase the ability of older adults with mental illness to live successfully in their communities by:

1. assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals, and
2. providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

This is to be accomplished by providing training and consultation to the staff serving the identified individuals, developing linkages with community providers serving older individuals and providing time limited specific direct services to the identified individuals.

Team Description: The teams are to consist minimally of a registered nurse and a masters prepared therapist and are to supplement current area program/LME capacity to serve adults, age 60 and over. The teams are to provide the majority of services where the individual lives rather than in an office/clinic setting. Team duties and activities may be assigned based on each team member's professional skills and abilities. Team members may perform some activities together when the situation calls for the professional skills of more than one team member. Team members must have the ability to communicate frequently and to meet face to face as needed.

Target Population: The target population includes:

1. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, who are in a state psychiatric hospital and who are preparing to return to the community to reside in a nursing home, adult care home or family residence
2. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, currently residing in a nursing home or adult care home who have mental health service/treatment needs and who may be at risk of psychiatric hospitalization.
3. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness who have significant mental health service or treatment needs and who may be at risk of psychiatric hospitalization and who are living with in their own home or with family members.

Team Activities:
Examples of the types of activities the team may provide ***to assist with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals*** include, but are not limited to, the following:

- provide information to AP/LME and state hospital regarding strengths and capabilities of nursing homes and adult care homes for individual discharge planning;
- assist in discharge planning with hospital staff and area program/LME and referral to identified service providers that have the ability to provide specific treatments, rehabilitative services and/or residential setting that are needed by the individual.
- provide consultative support to staff in the transition of individuals from state hospital to facility;
- provide consultation with staff, individual and family identifying interventions to ensure transition to community, alleviate behaviors that may threaten placement
- providing crisis-oriented face-to-face to the individual or phone support during normal work hours and liaison with crisis services as needed to prevent hospitalization or disruption of placement

Examples of the types of activities the team may provide ***to assist nursing homes, adult care homes, and other agencies or caregivers/families*** that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization include, but are not limited to, the following:

- provide case consultation with staff, individual and family regarding behaviors that may result in hospitalization or need for more intensive services
- assist staff to assess behaviors;
- provide input and support in the development of intervention plans;
- model for staff appropriate implementation of intervention plans as needed;
- provide services such as referrals to community services, assistance with obtaining benefits, time limited case management and/or time limited treatment and support services
- review of medication regime and educate staff in communication with psychiatrist, physician and pharmacist
- educate facility staff, other agencies and families on issues on such topics as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population
- provide resource information and identify ongoing training resources for staff
- provide a session of new staff orientation on such topics as individual rights;

Note: These funded Gero Specialty Teams are <u>not</u> expected to be primarily providers of direct services such as case management, community based service (CBS) or treatment services, but may do so on a time limited basis to assist in the transition to the community or to prevent hospitalization. If the individual requires on going direct services, the team

will contact the area program/LME and request the individual be referred to a provider of such services whenever such a provider is available in the community. The Gero Specialty Team intent is not to replace needed treatment, rehabilitative or support services. These time limited direct services will be provided only for identified individuals (i.e. those who meet age and diagnostic criteria and/or have been discharged from a state hospital).

Area Program/LME responsibilities. Each of the area programs/LMEs that received State funding for a Geriatric Mental Health Specialty Team is responsible for:

- ensuring that the team, whether as an area program service or as a contracted service, provides and documents services in a way that is consistent with all Division requirements including, but not limited to, human rights, training, confidentiality, client records, and reporting
- having an identified AP/LME person who is responsible for the team's operation, if operated by the AP/LME or having a primary contact person who is responsible for communication, problem solving, prompt payment, and oversight if the team is contracted out.
- establishing an agreement about how team services will be made available to other catchment area(s) if the allocation indicated that the team is to serve more than the funded area program/LME. This agreement should specify access to service parameters including how referrals will be made to the team and expectations regarding reporting, documenting, and billing for client specific direct services.

Questions about the Geriatric Mental Health Specialty Team model and guidelines from AP/LMEs should be directed to Debbie Webster, NC Div MH/DD/SAS, Community Policy Section, Best Practice Team, 3005 Mail Service Center, Raleigh, NC 27699-3005
Phone 919 715-2774
Email Debbie.Webster@ncmail.net

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

S 1

SENATE BILL 1148

Short Title:	Care for the Mentally Ill in LTC Facilities.	(Public)
Sponsors:	Senators Swindell, Allran, Dannelly, Moore, Queen; Bingham, Dalton, Hargett, Holloman, Kerr, Kinnaird, Lucas, Malone, and Purcell.	
Referred to:	Health & Human Resources.	

May 18, 2004

A BILL TO BE ENTITLED

AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study expanding the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. As part of this study, the Department shall consider renaming the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

SECTION 2. While undertaking the study, the Department of Health and Human Services shall proceed with implementation of the following:

(1) Standardizing these criteria across all Geriatric Mental Health Specialty Teams:
   a. Team purpose,
   b. Eligibility for services,
   c. Screening processes,
   d. Referral processes, and
   e. Forms, Training Manuals, Service Orders, and Authorizations.

(2) Tracking expenditure data for each Team and each Area Program/Local Management Entity.

(3) Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team.

SECTION 3. The Department of Health and Human Services shall submit an interim report to the North Carolina Study Commission on Aging by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number

of facilities served, clients served, and services provided by each Team. The Department shall submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging by October 30, 2005.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

HOUSE BILL 1356

Short Title:	Increase Fees/Qualifs. for DWI Assessments.	(Public)
Sponsors:	Representatives Alexander, Sauls, Insko (Primary Sponsors); Glazier and Rapp.	
Referred to:	Rules, Calendar, and Operations of the House.	

May 11, 2004

A BILL TO BE ENTITLED

AN ACT TO ENACT THE RECOMMENDATIONS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO ADMINISTER SUBSTANCE ABUSE ASSESSMENTS, TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR SUBSTANCE ABUSE ASSESSMENTS, TO STUDY THE MINIMUM QUALIFICATIONS OF INDIVIDUALS CONDUCTING ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOLS, AND TO STUDY THE FEE PAID BY DWI OFFENDERS FOR EDUCATION OR TREATMENT SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

(1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

(3) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM)."

SECTION 2. G.S. 122C-142.1(b1), as enacted in Section 1 of this act, reads as rewritten:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

(1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

~~(3) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.~~

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM)."

SECTION 3. G.S. 122C-142.1(f) reads as rewritten:

"(f) Fees. – A person who has a substance abuse assessment conducted for the purpose of obtaining a certificate of completion shall pay to the assessing agency a fee of ~~fifty dollars ($50.00).~~ one hundred dollars ($100). A person shall pay to a treatment facility or school a fee of seventy-five dollars ($75.00). If the defendant is treated by an area mental health facility, G.S. 122C-146 applies after receipt of the seventy-five dollar ($75.00) fee.

A facility that provides to a person who is required to obtain a certificate of completion a substance abuse assessment, an ADET school, or a substance abuse treatment program may require the person to pay a fee required by this subsection before it issues a certificate of completion. As stated in G.S. 122C-146, however, an area facility may not deny a service to a person because the person is unable to pay.

An area facility shall remit to the Department five percent (5%) of each fee paid to the area facility under this subsection by a person who attends an ADET school conducted by the area facility. The Department may use amounts remitted to it under this subsection only to support, evaluate, and administer ADET schools."

SECTION 4. Section 2 of S.L. 2003-396 reads as rewritten:

"**SECTION 2.** The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall study the programs offered by assessing agencies to clients who must obtain a substance abuse assessment and a certification of completion of a substance abuse program. The study should include information on the type of testing provided by an agency, the certification requirements for persons conducting alcohol and drug education traffic schools, the treatment offered by an agency, the average duration of a program, the average cost of treatment, the rates of recidivism, ~~and~~ the adequacy of the fee paid to the assessing agency by a client for a required substance abuse ~~assessment.~~ assessment and the adequacy of the fee paid to the treatment facility or school by a client for receiving

treatment or education. The Committee must report its findings and any recommended legislation to the ~~2004 Regular Session of the 2003~~ 2005 General Assembly."

SECTION 5. Section 1 of this act becomes effective October 1, 2005, and applies to substance abuse assessments conducted on or after that date. Section 2 becomes effective October 1, 2008, and applies to substance abuse assessments conducted on or after that date. Section 3 becomes effective October 1, 2004, and applies to substance abuse assessments administered on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 1356:
Increase Fees/Qualifs. For DWI Assessments

BILL ANALYSIS

Committee: Senate Health and Human Services
Date: June 2, 2004
Version: 1st Edition

Sponsor: Rep. Alexander, Sauls and Insko
Summary by: Sandra Alley
Committee Counsel

SUMMARY: House Bill 1356 is a recommendation of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The bill is in House Finance because it increases a fee. The bill does the following:

- *Increases fee DWI offender must pay for a substance abuse assessment from $50 to $100.*
- *Lists the following individuals who are authorized to conduct substance abuse assessments: certified substance abuse counselor, certified clinical addiction specialist, substance abuse counselor intern who is supervised by a certified clinical supervisor and who meets minimum qualifications, person licensed by NC Medical Board or NC Psychology Board, physician certified by the American Society of Addiction Medicine.*
- *Beginning October 1, 2008, substance abuse counselor interns may no longer conduct DWI assessments.*
- *Directs the Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities and Substance Abuse Services to study the certification requirements for persons conducting alcohol and drug education traffic (ADET) schools as well as fee that should be paid by a DWI offender who receives treatment or attends ADET school.*

CURRENT LAW: G.S. 20-17(a)(2) provides that the Division of Motor Vehicles (DMV) shall revoke the drivers' license of a person convicted of driving while impaired (DWI). DMV may restore the DWI offender's license if it receives a certificate of completion indicating that the driver has had a substance abuse assessment and either attended an ADET school or received substance abuse treatment. G.S. 20-17.6

G.S. 122C-142.1(f) provides that a person who has a substance abuse assessment done for purposes of obtaining a certificate of completion must pay $50 to the entity that conducts the assessment. The DWI offender must also pay a fee of $75 for ADET school or towards a substance abuse treatment. An area facility may not deny a service because of a person's inability to pay.

G.S. 122C-142.1(b) provides that to conduct a substance abuse assessment, a facility must use a standardized test approved by DHHS. The purpose of the DWI assessment is to determine whether the offender should attend an ADET school or obtain treatment for substance abuse. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission) has adopted Administrative Rules providing the qualifications for individuals performing DWI assessments:

- A credential issued by the NC Substance Abuse Professional Certification Board (Board) that acknowledges an individual is qualified to provide counseling for persons with substance abuse disorders; or
- A masters degree, one year of supervised experience in substance abuse counseling, and registration with the Board; or
- An undergraduate degree, two years of supervised experience in substance abuse counseling, and registration with the Board; or
- Graduation from high school or the equivalent, three years of supervised experience in substance abuse counseling, and registration with the Board; or
- Licensure by the NC Board of Medical Examiners or the NC Psychology Board; or
- Certification by the American Society of Addiction Medicine (ASAM).

Based on the assessment, the facility must make a recommendation that the client either attend an ADET school or obtain treatment. The recommendation must be reviewed and signed by a certified alcoholism, drug abuse, or substance abuse counselor, as defined by the Commission; a Certified Substance Abuse Counselor; or by a physician certified by the ASAM.

BILL ANALYSIS: **Section 1** amends G.S. 122C-142.1 by requiring that as of October 1, 2005 only the following persons are authorized to administer a DWI substance abuse assessment:

- A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.
- A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.
- A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.
- A person licensed by the NC Medical Board or the NC Psychology Board
- A physician certified by the American Society of Addiction Medicine (ASAM)

Section 2 provides that as of October 1, 2008, Substance Abuse Counselor Interns will no longer be able to administer DWI substance abuse assessments.

Section 3 amends G.S. 122C-142.1(f) to increase the fee, from $50 to $100, that a DWI offender must pay to obtain a substance abuse assessment. The fee increase applies to assessments conducted on or after October 1, 2004. (In SB 934, ratified last session, the House version of SB 934 increased this fee from $50 to $75. The ratified bill did not include an increase for this fee.)

Section 4 directs the Oversight Committee to study the certification requirements for persons conducting ADET schools and also the fee that a DWI offender should pay to attend an ADET school or receive treatment for substance abuse. The Committee is directed to submit its recommendations to the 2005 General Assembly.

Martha Walston, Fiscal Research Division, contributed substantially to this summary.

VISITOR REGISTRATION SHEET

Health and Human Resources — June 2, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Leonidas, CRNA	NCANA - Nurse of day.
ginette A. AACHINAL	CARY FAMILY HEALTHCARE PA "Doctor of the DAY"
Joseph Rick	Wake Forest University Masters in Counseling Grad Student
Jessica Hylton	Wake Forest University Counseling student
Paul Decker	Wake Forest University Counselling
Sarah Mitchell	Wake Forest University Counseling Graduate Student
Dr. Laura Veach	Wake Forest University 27109 Dept. of Counseling, PO Box 7406, W-SNC
Leah Stone	Wake Forest University Counseling Graduate Student
Jennifer Beem	WFU Counseling Graduate Program
Ted Lakoski	WFU Counseling Program
Starla McKenney	NC DHHS

VISITOR REGISTRATION SHEET

Health and Human Resources — June 2, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jason Reynolds	DMHDDSAS
Luke Gunby	off. of Gov.
DAVID M. BARNES	Poyner + Spruill LLP
Katherine Townsend	AEP - Phoenix Raleigh, NC
MICHAEL GLASS	COSTRAN, INC.
Roz Sewell	NDCCCC
John Cyrus	nc state Energy
Barbara Carolan	BSGR
Mari Leon	NCSA
ANN WILL	DUNS
Angela Horne	NCMS
Stacy Flannery	NCACPP

VISITOR REGISTRATION SHEET

Health and Human Resources — June 2, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leila Kahwati, MD MPH	UNC Preventive Medicine Residency Program Chapel Hill, NC
ED BRIDGEFORD MD MPH	"
Jane Kim MD	"
SAVI NAGESWARAN MD	"
Aysha Akhtar MD	" "
AMY ISENBERG MD, MPH	"
Deborah Porterfield, MD, MPH	" "
[illegible] McHugh	box office
Jeff Lipe	Bayer
My [illegible]	DHHS - BAA
Sonya Brown	DMH DD SAS
Steve Keene	NCMS
James Ranquist	NCIMS

VISITOR REGISTRATION SHEET

Health and Human Resources — June 2, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Delk	Gov. Office
Barden Grimes	NCSAPCB / NCBHS
[signature]	J&J, P.A.
John Bowdish	AstraZeneca
Brian Shank	AstraZeneca
Rick Webb	NCAA Intern
[signature]	Staff
George Childs	Rocky Mt. Telegram

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health and Human Resources** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 30, 2004	11:00 AM	544, LOB

The following will be considered:

	BILL NO.	SHORT TITLE	SPONSOR
•	HB 1469	DHHS Disease Management Activities	Representative Nye
•	SB 444	School Info/Meningitis and Flu	Senator Hagan

Senator William Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

AGENDA

SENATE HEALTH & HUMAN RESOURCES COMMITTEE
June 30, 2004 at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

H.B. 1469, DHHS Disease Mgmt. Activities

S.B. 444, School Info/Meningitis and Flu

III. Other Business

IV. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT

Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 30, 2004

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

FAVORABLE

H.B.(CS #1) **1469** DHHS Disease Mgmt Activities.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

CORRECTED REPORT

Tuesday, July 06, 2004

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

FAVORABLE AS TO CONCURRENCE

S.B.(HCS #1) **444** School Info/Meningitis and Flu.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, June 30, 2004
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health and Human Resources Committee met at 11:00 A.M. on Wednesday, June 30, 2004 in Room 544 of the Legislative Office Building. Ten members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell and Senator Stan Bingham, Co-Chair, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell introduced Representative Edd Nye to present his bill, HB 1469, *DHHS Disease Management Activities* to the Committee. Senator Purcell asked if this bill would come under the auspices of the Carolina Community Care program. Rep. Nye answered that it would. Senator Purcell added that he was pleased to see that this legislation would deal with adult diseases as well as those of children. Senator Dannelly asked for an example of how this would manage costs. Rep. Nye cited obesity as an example, that a lifestyle change could be effected through case management, as could asthma, diabetes, and lung diseases. Senator Kinnaird pointed out that many of these diseases are tobacco-related, and that it would be helpful if the tax on tobacco could be raised. Senator Dannelly moved for a favorable report for this bill.

Senator Purcell recognized Representative Martha Alexander to explain SB 444, *School Info/Meningitis and Flu.* She explained the history of the bill, and the reason for its being. Senator Forrester pointed out that influenza vaccine is recommended for children at risk, not all children, but Senator Purcell said that he believes that has expanded to include most children. Rep. Alexander, in response to another question from Senator Forrester said that this bill would include home and church related schools. Senator Forrester asked if this bill would cost money; that there was no provision in the bill for funds for dissemination of material. Rep. Alexander said that a memorandum had been prepared stating that there would be very low or no cost, and that she would request a formal fiscal note if the Committee requested it. Senator Lucas observed that all school budgets are being "chipped away at" and that any potential costs to school budgets should be recognized. Senator Malone asked at what age children are susceptible to these diseases. Senator Purcell said that children older than several months are at risk and is more commonly seen in older persons. Senator Malone voiced a concern for children younger than school age. Senator Forrester suggested that pharmaceutical companies who make these vaccines might be willing to assume the cost of materials for dissemination of this information. Senator Lucas asked how widespread meningitis is, and Senator Purcell said that meningococcal meningitis is fairly rare and from a strictly public health standpoint would not be cost effective to give the vaccine to everyone. From an individual standpoint it may be cost effective. Senator Allran moved for a favorable report, pending receipt of a fiscal note before the bill is reported out.

The meeting adjourned at 11:40 A.M.

William R. Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 1469

Committee Substitute Favorable 6/17/04

Short Title: DHHS Disease Mgmt Activities. (Public)

Sponsors:

Referred to:

May 17, 2004

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INITIATE OR CONTINUE CERTAIN DISEASE MANAGEMENT ACTIVITIES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON THE RISING COST OF HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall take action to address the rising cost of health care provided under the State Medical Assistance Plan as follows:

(1) Adopt contractual agreements with providers of services that require and reward use of evidence-based practice standards and guidelines for Medicaid and NC Health Choice.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall:

a. Ensure collaboration between local management entities providing mental health services and Community Care of North Carolina providers that serve Medicaid enrollees diagnosed with depression, and

b. Require evidence-based practices for the treatment of psychotic illnesses.

(3) The Division of Medical Assistance shall consider the following as it develops plans to improve the quality, utilization, and cost-effectiveness of the State's Medicaid program:

a. New disease management initiatives that target such costly diseases or conditions as congestive heart failure, chronic lung disease, chronic kidney disease, sickle cell disease, and low birth weight.

b. Collaborate with the Division of Public Health and other community organizations to improve the coordination and

implementation of key initiatives to address obesity, premature birth, and smoking cessation.

c. Collaborate with local management entities that provide mental health services to develop local systems and processes that enhance the ability of primary care physicians to care for nontargeted mental illness and substance abuse clients.

d. Use case management processes to improve the utilization and access to such community-based services as ancillary and in-home support services.

e. Investigate the use of incentives or technology to promote the effective use of evidence-based guidelines by Program participants.

The Department shall report on the progress of these activities to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services not later than March 1, 2005.

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

HOUSE BILL 1469:
DHHS Disease Mgmt Activities

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Reps. Nye, Barbee, Justus, Insko
Date:	June 30, 2004		
Version:	Second Edition	**Summary by:**	Sandra Alley Committee Counsel

SUMMARY: ***House Bill 1469 would require the Department of Health and Human Services to initiate or continue certain disease management activities in the State's Medicaid program and to consider other actions to contain health care costs. The bill is a recommendation of the House Select Committee on the Rising Cost of Health Care. The bill would become effective when it becomes law.***

CURRENT LAW: States are pursuing ways to contain escalating costs in their Medicaid programs. One cost containment strategy being undertaken by over half of the states is the implementation of disease management programs. Disease management (DM) programs are designed to improve health care outcomes and reduce costs by identifying patients with certain high cost chronic conditions, educating those patients on how to better manage their health, improving provider awareness and adherence to evidence-based care strategies, and establishing coordinated care interventions and follow-up systems to prevent unnecessary and more expensive health complications.

Community Care of North Carolina (formerly Carolina Access II and III) is the State's Medicaid program of community-based medical care management. The central philosophy of Community Care is to develop local networks of primary care providers to coordinate prevention, treatment, referral and institutional services for Medicaid beneficiaries. Current disease management initiatives being undertaken in Community Care include programs for asthma and diabetes. Pilot programs are being undertaken for depression, ADHD, special needs children, gastroenteritis, otitis media, and low birth weight.

Another strategy states are undertaking to control Medicaid costs is to implement supplemental rebates for prescription drugs. Federal law (OBRA '90) requires drug manufacturers to enter into national rebate agreements with the U.S. Department of Health and Human Services for states to receive federal funding for drugs dispensed to Medicaid patients. Supplemental rebates are additional rebates to a state's Medicaid program that are above and beyond those required by federal law. North Carolina does not have a supplemental rebate program, but the Secretary of Heath and Human Services could implement one.

Using evidence-based practices in medicine has also been recommended as a method to save health care costs. Using evidence-based practices involves applying the best available scientific evidence to make decisions about the care of individual patients.

BILL ANALYSIS: House Bill 1469 would require the Department of Health and Human Services to take the following actions:

- Adopt contractual agreements that require and reward evidence-based practice standards.
- Require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure collaboration between local providers and Community Care providers that service Medicaid enrollees diagnosed with depression and require evidence-based practices for the treatment of psychotic illnesses.

- Require the Division of Medical Assistance to consider new disease management initiatives, collaborate with the Division of Public Health and other community organizations to improve coordination and implementation of key initiatives to address obesity, premature birth, and smoking cessation, collaborate with local management entities to develop ways to care for nontargeted mental illness and substance abuse clients, use casement management processes to improve utilization and access to community-based services, and investigate the use of incentives or technology to promote the effective use of evidence-based guidelines in the Medicaid program.

The Department would be required to report on the progress of these activities to the House and Senate health and human services appropriations subcommittees no later than March 1, 2005.

BACKGROUND: The Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill undertook has studied the effects of the disease management efforts within Community Care. Findings from the Sheps Center show a CY2002 savings of $1,580,000 in the asthma program and a three year cost savings for diabetes care of approximately $2.1 million. The Sheps findings also indicate there could have been a potential savings of more than $11.3 million in 2003 had Community Care been implemented statewide for asthma and diabetes disease management.

Dianna Jessup, Staff Attorney, contributed significantly to this summary.

SCHOOL INFO/MENINGITIS AND FLU: Senate Bill 444

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Hagan/PCS - Alexander
Date:	June 30, 2004	**Summary by:**	Sara Kamprath
Version:	Third Edition		Committee Analyst

SUMMARY: ***The Third Edition of Senate Bill 444 would ensure that information concerning meningitis and influenza, and their vaccines, is available for schools to provide to parents and guardians. The act would become effective July 1, 2004, and apply beginning with the 2004-2005 school year.***

CURRENT LAW: Information concerning meningitis and influenza, and their vaccines, is available. However, there is no requirement that it be made available to schools so they can provide it to parents or guardians.

SECTION-BY-SECTION ANALYSIS:

Section 1 would provide that the act be known as "Garrett's Law."

Section 2 would direct local school boards to provide parents and guardians with information about meningitis and influenza, and their vaccines, at the beginning of every school year.

Section 3 would require the Department of Public Instruction to ensure that charter schools make this information available to parents and guardians at the beginning of every school year.

Sections 4, 5, and 6 would require the Division of Non-Public Education (Division), Department of Administration, to ensure that this information is available so that non-public schools, including home schools, can provide it to parents and guardians. The Division may provide the information electronically or on its webpage.

Section 7 would direct the Division of Public Health, Department of Health and Human Services (DHHS), to make available to local school administrative units, the Department of Public Instruction, and the Division sample educational materials that can be provided to parents and guardians. DHHS may provide this information electronically.

Section 8 would provide that the act becomes effective July 1, 2004, beginning with the 2004-2005 school year.

BACKGROUND: According to the Centers for Disease Control (CDC), meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. Meningococcal meningitis is caused by bacteria, is contagious, and is considered more dangerous than viral meningitis. According to the National Meningitis Association, there are 2,000 to 3,000 annual cases in the United States and they are increasing among adolescents. Of these cases, almost one-third result in fatalities or severe disabilities such as limb amputations or organ damage.

Influenza, according to the CDC, is a contagious respiratory illness that can result in illness ranging from mild to severe and life-threatening complications. An estimated 10% to 20% of U.S. residents get the flu each year; an average of 114,000 people are hospitalized with complications from the flu; and 36,000 Americans die each year from these complications.

Vaccinations are available for both meningitis and influenza.

In 2003, the General Assembly directed each public or private educational institution that offers a postsecondary degree and that has a residential campus to provide vaccination information on meningococcal disease to each student.

S444-SMRJ-003

Robin Johnson contributed significantly to this summary.

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **JUNE 30, 2004**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCLHW
[signature]	Cabe Alexander PLLC
[signature]	Capitol Group
DAVID BARNES	Poyner Spruill
Marvin Musselwhite	" "
[signature]	UHS
JEFF ENGEL	NC DHHS
Trisha Hardin	Gov. policy office
Abby Emanuelson	Nat'l MS Society
[signature]	NCSA
Kathy Hartkopf	NC Citizens for a Sound Economy

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **JUNE 30, 2004**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Cyrus	NC Grange
Crissy Porter	Smith Anderson
Ann Lore	DVHS
John Bowdish	Astra Zeneca
Joanne Stevens	NCNA
Matt Sheffield	Boehringer Ingelheim
Tony Hayes	NC Pork Council
Rich Webb	NCGA Intern
Starla McKenney	NC DHHS
Jose Garcia-para	NCACC
[illegible]	[illegible]
Jim Siggin	NCCH
Evelyn Holthouse	EHCR

Lyn Dillon - NCAHCP

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN RESOURCES — **Name of Committee**

JUNE 30, 2004 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Adam Pridemore	WCASA
Alan Wells	FLR
Wayne Yan	Staff
ROB LAMME	NHHS
John A. Cole	
Myron Terry	Pfizer
Steve Mitchell	Novartis
Gary Salamido	GlaxoSmithKline

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, July 14, 2004
3:35 P.M.
Senate Chamber, Legislative Building

MINUTES

The Senate Health and Human Resources Committee met at 3:35 P.M. on Wednesday, July 14, 2004, around Senator Purcell's desk in the Senate Chamber in the Legislative Building. Six members were present. Senator William R. Purcell, Co-Chair presided. Senator Purcell turned the meeting over to Co-Chair Senator Stan Bingham in order that he could present H.B. 669, *Hospitals/LTC Quality Assurance* to the committee members.

Senator Purcell presented a Proposed Committee Substitute to the committee. A motion was made and passed to consider the Proposed Committee Substitute in place of the bill. Senator Purcell explained the provisions of the Proposed Committee Substitute. Senator Dannelly made a motion for a favorable committee report, unfavorable as to the original bill, favorable to the PCS. Senator Forrester asked to be excused from the vote, citing a potential conflict of interest. The motion passed.

The meeting adjourned at 3:45 P.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH & HUMAN RESOURCES COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, July 14, 2004

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) **669** Hospital Licensure/Critical Access Hospital.

Draft Number:	PCS 70509
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H D

HOUSE BILL 669

Committee Substitute Favorable 4/9/03

PROPOSED SENATE COMMITTEE SUBSTITUTE H669-CSSP-21 [v.16]

7/13/2004 1:37:14 PM

Short Title: Hospitals/LTC Quality Assurance. (Public)

Sponsors:

Referred to:

March 26, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF A "PRIMARY CARE HOSPITAL" TO REFLECT FEDERAL REQUIREMENTS, TO IMPROVE THE QUALITY OF PATIENT CARE, TO PROTECT PATIENT-PHYSICIAN RELATIONSHIPS AND TO LIMIT MEDICAL DIRECTORS LIABILITY.

The General Assembly of North Carolina enacts:

PART I. CHANGE DEFINITION OF PRIMARY CARE HOSPITAL TO REFLECT FEDERAL REQUIREMENTS.

SECTION 1.1 G.S. 131E-76 reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(2) "Governing body" means the Board of Trustees, Board of Directors, partnership, corporation, association, person or group of persons who maintain and control the hospital. The governing body may or may not be the owner of the properties in which the hospital services are provided.

(3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes

licensed under G.S. 131E-102, and adult care homes licensed under G.S. 131D-2.

(4) "Infirmary" means a unit of a school, or similar educational institution, which has the primary purpose to provide limited short-term health and nursing services to its students.

(5) "Medical review committee" means a committee of a State or local professional society, of a medical staff of a licensed hospital or a committee of a peer review corporation or organization which is formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing.

(6) ~~"Primary care hospital"~~ "Critical access hospital" means a hospital which has been designated as a ~~primary care~~ critical access hospital by the North Carolina Department of Health and Human Services, Office of Rural Health and Resource Development. To be designated as a ~~primary care~~ critical access hospital under this subdivision, the hospital must ~~be located in a rural community, provide primary care inpatient services that do not include inpatient surgery, and provide outpatient services which may include outpatient surgery. A primary care hospital shall have a maximum annual average daily census of 15 patients and may have psychiatric and long-term care distinct part units. A primary care hospital must be part of a rural hospital network.~~meet the requirements of federal law for certification as a critical access hospital.

(7) "Rural hospital network" means an alliance of members that shall include at least one ~~primary care~~ critical access hospital and one other hospital. To qualify as a rural hospital network, the ~~members~~ critical access hospital must submit a comprehensive, written memorandum of understanding to the Department of Health and Human Services for the Department's approval. The memorandum of understanding must include provisions for patient referral and transfer, a plan for network-wide emergency services, and a plan for sharing patient information and services between hospital members including medical staff credentialing, risk management, quality assurance, and peer review."

PART II. MEASURES TO IMPROVE THE QUALITY OF PATIENT CARE.

SECTION 2.1. G.S. 131E-101 is amended by adding a new subdivision to read:

"(8) "Quality assurance committee" means a committee, agency, or department of a state or local professional organization, of a medical staff of a licensed hospital, nursing home, of nurses or aides on the staff of a nursing home, or adult care home, of physicians having privileges within the nursing home, or adult care home, or of a peer review corporation or organization that is formed for the purpose of evaluating the quality, cost of, or necessity for health care services under applicable federal and State statutes, regulations, and rules."

SECTION 2.2. G.S. 131E-107 reads as rewritten:

"**§ 131E-107. ~~Medical~~ Quality assurance, medical, or peer review committees.**

(a) A member of a duly appointed ~~medical~~ quality assurance, medical or peer review committee 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, if the committee member acts without malice or fraud, and if such peer review committee is approved and operates in accordance with G.S. 131E-108.

(b) The proceedings of a quality assurance, medical, or peer 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 nursing home or a provider of professional health services that results from matters that 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. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered 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 the person's testimony before the committee or any opinions formed as a result of the committee hearings."

SECTION 2.3. Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-21.2. Quality assurance, medical, or peer review committees.**

(a) A member of a duly appointed quality assurance, medical or peer review committee 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, if the committee member acts without malice or fraud, and if such peer review committee is approved and operates in accordance with G.S. 131D-21.1.

(b) The proceedings of a quality assurance, medical, or peer 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 nursing home or a provider of professional health services that results from matters that 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. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered 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 the person's testimony before the committee or any opinions formed as a result of the committee hearings."

SECTION 2.4. G.S. 131E-76(5) reads as rewritten:

"(5) "Medical review committee" means ~~a committee of a State or local professional society, of a medical staff of a licensed hospital or a committee of a peer review corporation or organization which is~~ any of the following committees formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff ~~credentialing.~~ credentialing:

a. A committee of a state or local professional society.

b. A committee of a medical staff of a hospital.

c. A committee of a hospital or hospital system, if created by the governing board or medical staff of the hospital or system or operating under written procedures adopted by the governing board or medical staff of the hospital or system.

d. A committee of a peer review corporation or organization."

SECTION 2.5. 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, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, 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. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered 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~~ the person's 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.~~ including the Joint Commission on Accreditation of Healthcare Organizations. Information released under this ~~subdivision~~ subsection 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~~ subsection 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.~~ this section."

SECTION 2.6. G.S. 90-21.22A reads as rewritten:

"**§ 90-21.22A. Medical review and quality assurance committees.**

(a) As used in this section, the following terms mean:

(1) "~~medical~~ Medical review ~~committee~~"committee." ~~–~~ A ~~means a~~ committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. "Medical review committee" does not mean a medical review committee established under G.S. 131E-95.

(2) "Quality assurance committee." – Risk management employees of an insurer licensed to write medical professional liability insurance in this State, who work in collaboration with health care providers licensed under this Chapter, and insured by that insurer, to evaluate and improve the quality of health care services.

(b) A member of a duly appointed medical review or 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.

(c) The proceedings of a medical review or quality assurance 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, 131E-309, or 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that 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. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about ~~his or her~~ the person's testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under G.S. 58-50-61 or G.S. 58-50-62."

SECTION 2.7. 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.

(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. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the

committee. 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~~ the person's 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~~ this section 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.~~function, including the Joint Commission on Accreditation of Healthcare Organizations. 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,~~this subsection, and the standards review organization shall keep the information confidential subject to ~~that subdivision.~~this section."

SECTION 2.8. G.S. 122C-30 reads as rewritten:

"**§ 122C-30. Peer review committee; immunity from liability; confidentiality.**

For purposes of peer review functions of a ~~hospital~~ facility licensed under the provisions of this Chapter:

(1) A member of a duly appointed peer review committee or 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

(2) Proceedings of a peer review or 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. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. 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 or quality assurance process, but cannot be asked about ~~his~~ the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings."

SECTION 2.9. Article 1B of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-21.18A. Medical directors; liability limitation.**

A medical director of a licensed nursing home shall not be named a defendant in an action pursuant to this Article except under any of the following circumstances:

(1) Where allegations involve a patient under the direct care of the medical director.

(2) Where allegations involve willful or intentional misconduct, recklessness, or gross negligence in connection with the failure to supervise, or other acts performed or failed to be performed, by the medical director in a supervisory or consulting role."

PART III. MEASURES TO PROTECT PATIENT-PHYSICIAN RELATIONSHIPS.

SECTION 3.1. Article 4 of Chapter 8C of the General Statutes is amended by adding a new section to read:

"**Rule 413. Medical actions; statements to ameliorate or mitigate adverse outcome.**

Statements by a health care provider apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and gratuitous acts to assist affected persons shall not be admissible to prove negligence or culpable conduct by the health care provider in an action brought under Article 1B of Chapter 90 of the General Statutes."

PART IV. EFFECTIVE DATES.

SECTION 4.1. This act is effective when it becomes law. Sections 2.9 and 3.1 apply to causes of action arising on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 669
Committee Substitute Favorable 4/9/03

Short Title: Hospital Licensure/Critical Access Hospital. (Public)

Sponsors:

Referred to:

March 26, 2003

A BILL TO BE ENTITLED

AN ACT TO AMEND THE DEFINITION OF A "PRIMARY CARE HOSPITAL" TO REFLECT FEDERAL REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-76 reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(2) "Governing body" means the Board of Trustees, Board of Directors, partnership, corporation, association, person or group of persons who maintain and control the hospital. The governing body may or may not be the owner of the properties in which the hospital services are provided.

(3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, and adult care homes licensed under G.S. 131D-2.

(4) "Infirmary" means a unit of a school, or similar educational institution, which has the primary purpose to provide limited short-term health and nursing services to its students.

(5) "Medical review committee" means a committee of a State or local professional society, of a medical staff of a licensed hospital or a committee of a peer review corporation or organization which is formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing.

(6) ~~"Primary care hospital"~~ "Critical access hospital" means a hospital which has been designated as a ~~primary care~~ critical access hospital by the North Carolina Department of Health and Human Services, Office of Rural Health and Resource Development. To be designated as a ~~primary care~~ critical access hospital under this subdivision, the hospital must ~~be located in a rural community, provide primary care inpatient services that do not include inpatient surgery, and provide outpatient services which may include outpatient surgery. A primary care hospital shall have a maximum annual average daily census of 15 patients and may have psychiatric and long-term care distinct part units. A primary care hospital must be part of a rural hospital network.~~ meet the requirements of federal law for certification as a critical access hospital. A hospital designated as a critical access hospital shall, at a minimum, offer primary outpatient services and ensure the availability of 24-hour emergency services. A critical access hospital must be part of a rural hospital network.

(7) "Rural hospital network" means an alliance of members that shall include at least one ~~primary care~~ critical access hospital and one other hospital. To qualify as a rural hospital network, the ~~members~~ critical access hospital must submit a comprehensive, written memorandum of understanding to the Department of Health and Human Services for the Department's approval. The memorandum of understanding must include provisions for patient referral and transfer, a plan for network-wide emergency services, and a plan for sharing patient information and services between hospital members including medical staff credentialing, risk management, quality assurance, and peer review."

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

HOUSE BILL 669:
Hospitals/LTC Quality Assurance

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Sen. Purcell
Date:	July 1, 2004	**Summary by:**	Sandra Alley
Version:	H669-CSSP-21 [v.16]		Committee Counsel

SUMMARY: ***Part I of the Proposed Committee Substitute for House Bill 669 would amend the definition of "primary care hospital" in Article 5, of Chapter 131E, governing the licensure of hospitals. The change is necessary to conform the definition to changes in federal law that has resulted in the conversion of "primary care" hospitals to "critical access" hospitals.***

Part II and III of the PCS would adopt measures aimed at improving the quality of patient care in nursing and adult care homes, provide liability limitations for lawsuits against medical directors in nursing homes, and allow health care providers to apologize to patients without the apology being admitted as evidence of negligence in a civil action.

Section 2.9 and 3.1 of the PCS would apply to cause of action arising on or after the effective date and the remainder of the act would become effective when it becomes law.

CURRENT LAW: Under current law, the Department of Health and Human Services, Office of Rural Health and Resource Development designates a hospital as a "primary care hospital" if the hospital:

- Is located in a rural community;
- Provides primary care inpatient services that do not include inpatient surgery;
- Provides outpatient services that may include outpatient surgery;
- Has a maximum average daily census of 15 patients;
- May have distinct long-term care or psychiatric units;
- Be a part of a rural care network that includes a larger hospital.

These primary care hospitals are likely to meet the conditions necessary to be certified under federal law as a critical access hospital and as a result the current definition is out of date.

BILL ANALYSIS:

Part I. Change definition of primary care hospital to reflect federal requirements.

Section 1.1 makes the following changes to G.S. 131E-76:

- Deletes the term "primary care hospital" and replaces it with "critical care access hospital";
- Provides that to be a critical access hospital must meet the requirements of federal law to become certified; and
- Offer primary outpatient services, 24-hour emergency services, and be a member of a rural hospital network.

Part II. Measures To Improve The Quality Of Patient Care.

Section 2.1 creates a new subsection under G.S. 131E-101 to define "Quality assurance committee" in the context of hospitals, nursing homes, and adult care homes.

Section 2.2 amends G.S. 131E-107 to make meetings of quality assurance committees and medical or peer review committees of nursing homes confidential. The materials prepared for those meetings are not public records, and are not subject to discovery or admissible into evidence. Information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because the committee considered them. No person attending a quality assurance, medical or peer review committee meeting shall be required to testify in a civil action about the committee meeting.

Section 2.3 creates G.S. 131D-21.2 is identical to the provision in Section 2.2 but applies in the context of adult care homes.

Section 2.4 amends G.S. 131E-76(5) to add a committee of a hospital or hospital system to the existing definitions of a "Medical review committee".

Section 2.5 rewrites G.S. 131E-95 to clarify that certain information discussed or studied by a medical review committee is confidential and is not subject to discovery in a civil action. The information may be released to the Joint Commission on Accreditation of Healthcare Organizations as reasonably necessary, would retain its confidentiality, and would not be subject to discovery in a civil action.

Sections 2.6 – 2.8 rewrites various statutes to give quality assurance committees made up of risk management employees of insurers, quality assurance committees for nursing homes, and members of peer review committees for nursing homes the same protections given to medical review committees with respect to liability and the protection of information considered by those committees. The same information listed in Section 2.5 (above) would be considered confidential and not subject to discovery.

Section 2.9 creates G.S. 90-21.18A, Medical directors; liability limitation, to provide that a medical director of a licensed nursing home shall not be named a defendant in a medical malpractice action unless the allegations involve a patient under the physician's direct care, or involve willful or intentional misconduct, recklessness or gross negligence in connection with the failure to supervise or perform certain acts.

Part III. Measures To Protect Patient-Physician Relationships.

Section 3.1 creates Rule of Evidence 413 to prohibit statements by a health care provider apologizing or making offers to take corrective measures from being admissible as evidence of negligence in a medical malpractice action.

Part IV. Effective dates. Section 2.9 and 3.1 of the PCS would apply to causes of actions arising on or after the effective date, the remainder of the bill becomes effective when it becomes law.