2005-2006

SENATE
HEALTH CARE

COMMITTEE
MINUTES

SENATE COMMITTEE ON HEALTH AND HUMAN RESOURCES

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

Stan Bingham, CoChair
Judy Chriscoe 3-5665

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

Katie Dorsett, Vice Chair
5-3042

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

Doug Berger
Linda Laton 5-8363

Charlie S. Dannelly
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Phyllis Porter 3-5742

Eddie Goodall
Elizabeth Slocum 3-7859

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

David W. Hoyle
Penny Williams 3-5734

Jim Jacumin
Janet Black 5-7823

Ellie Kinnaird
Kathy Young 3-5804

Jeanne Lucas
Bernie David-Yerumo 3-4599

Vernon Malone
Claudette Howell 3-5880

Martin L. Nesbitt, Jr.
Janette Lee 5-3001

Tony Rand
Evelyn Costello 3-9892

Lorraine Blake, Committee Assistant
Judy Chriscoe, Committee Assistant

Dianna Jessup, Research
Ben Popkin, Research

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0035	Alexander	ADET SCHOOL/FEE/ QUALIS. INCREASE.	*SR	Ch. SL 2005-312	05-09-05	05-18-05
45=	Nye	ADULT PROTECTIVE SERVICES TF/ COLLABORATE.	SR	Ch. SL 2005-23	03-16-05	04-13-05
H0239	Wainwright	SMOKING IN PUBLIC PLACES/LOCAL HEALTH DEPT.	*SR	Ch. SL 2005-19	03-23-05	04-13-05
H0277	Glazier	ESTABLISH CHILD ASSESSMENT RESPONSES.	*SR	Ch. SL 2005-55	04-07-05	05-04-05
H0496	Harrison	STUDENT ASTHMA MEDICATIONS.	*SR	Ch. SL 2005-22	04-05-05	04-20-05
H0613	Harrell	UPDATE CERTIFICATION/ LICENSURE/REC. THERAPY.	*SR	Ch. SL 2005-378	05-24-05	08-10-05
H0636	Nye	ANATOMIC PATHOLOGY SERVICES/PROVIDER BILLING.	*SR	Ch. SL 2005-415	06-02-05	08-10-05
H0686	Gibson	UPDATE DISABILITY STATUTES/SERVICE ANIMALS.	*SR	Ch. SL 2005-450	04-07-05	05-16-05
H0707	Alexander	AMEND STAR-RATED LICENSURE/CHILD CARE FAC.-AB	*SR	Ch. SL 2005-36	04-14-05	04-27-05
H0780	Yongue	NEED-BASED NURSING SCHOLARSHIPS.-AB	*SR	Ch. SL 2005-40	04-18-05	05-04-05
H0855	Insko	CHILD NUTRITION STANDARDS.	*SR	Ch. SL 2005-457	06-02-05	08-10-05
H0869	Wright	PUBLIC HOSPITAL AMENDMENTS/DOWNTOWN FACILITY	*SR	Ch. SL 2005-70	04-13-05	05-25-05
74	Goodwin	TITLE CHANGE/SAFETY AND HEALTH REVIEW BOARD.	*SR	Ch. SL 2005-133	05-25-05	06-15-05
H0916	Gillespie	HEMOPHILIA DRUGS/ REMOVE SUNSET ON PRIOR AUTH.	*SR	Ch. SL 2005-83	05-11-05	06-02-05
H1059	Wright	PUBLIC SCHOOL HEALTH CURRICULUM.	*S	Re-ref Com On Education/Higher Education	06-06-05	07-06-05
H1060	Wright	HOSPITAL LICENSE/ CONFORMING CHANGE.	*SR	Ch. SL 2005-346	04-14-05	08-23-05
H1077	Sherrill	BIRTH CERTIFICATE/ STILLBORN INFANTS.	*S	Ref To Com On Health Care	04-20-05	
H1121	Rayfield	HOSPITAL AUTHORITY.	*SR	Ch. SL 2005-449	05-23-05	08-11-05
H1301	L. Allen	PHYSICAL THERAPY BD./ COMPETENCY OF LICENSEES.	*S	Ref To Com On Health Care	05-23-05	
H1327	Harrison	CRIM. RECORD CHECKS/ PSYCHOLOGY PRACTICE ACT.	*S	Re-ref Com On Finance	07-14-05	08-10-05
H1330	Jeffus	AMEND ELECTROLYSIS PRACTICE ACT/FEES.	*S	Ref to Health Care. If fav, re-ref to Finance	08-24-05	
H1357	Fisher	AMEND ACUPUNCTURE LAWS/FEES.	*SR	Ch. SL 2005-379	05-18-05	06-15-05

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H1482	Pierce	SMOKING IN PUBLIC PLACES/LOCAL HEALTH/ DSS.	*SR	Ch. SL 2005-168	06-06-05	06-22-05
H1493	Cole	PHARMACY QUALITY ASSURANCE PROTECTION ACT.	*SR	Ch. SL 2005-427	08-09-05	08-10-05
H1493	Cole	PHARMACY QUALITY ASSURANCE PROTECTION ACT.	*SR	Ch. SL 2005-427	08-10-05	08-10-05
H1507	Alexander	AMEND INTERPRETER/ TRANSLITERATOR LICENSE ACT.	SR	Ch. SL 2005-299	05-25-05	06-22-05
S0003	Tony Rand	AUTHORIZE COMPETENCY REQ./NC BD. OF NURSING.	*SR	Ch. SL 2005-186	01-27-05	02-23-05
S0036=	A. B Swindell	ADULT PROTECTIVE SERVICES TF/ COLLABORATE.	S	Ref To Com On Health Care	02-03-05	
S0040=	A. B Swindell	FALSIFY INFO/ADULT CARE HOME LICENSE/ PENALTY.	S	Ref To Com On Health Care	02-03-05	
$ S0042=	**A. B Swindell**	**HOME CARE CHANGES.**	***S**	**Ref To Com On Aging**	**02-03-05**	**06-01-05**
$ S0045	**Katie G. Dorsett**	**ACCESSIBLE ELECTRONIC INFO ACT/BLIND/ DISABL'D.**	***S**	**Re-ref Com On Appropriations/ Base Budget**	**02-03-05**	**03-10-05**
S0072	Kay R. Hagan	EXPAND COUNTY BOARD OF HEALTH MEMBERSHIP.	*S	Ref To Com On Health	02-08-05	02-23-05
S0083=	Charlie S. Danne	ADET SCHOOL/FEE/ QUALIFICATIONS INCREASE.	*S	Re-ref Com On Finance	02-09-05	02-23-05
S0118=	William R. Purce	MEDICAID CASE MANAGEMENT/ PRESCRIPTION DRUGS.	S	Re-ref Com On Health Care	02-14-05	03-30-05
S0118=	William R. Purce	MEDICAID CASE MANAGEMENT/ PRESCRIPTION DRUGS.	S	Re-ref Com On Health Care	03-31-05	
$ S0119=	**William R. Purce**	**TICKET TO WORK/ MEDICAID ELIGIBILITY.**	***S**	**Re-ref Com On Appropriations/ Base Budget**	**02-14-05**	**04-13-05**
S0120=	William R. Purce	EXPAND MEDICAID ELIGIBILITY TO CHILDREN/200%.	*S	Re-ref Com On Appropriations/ Base Budget	02-14-05	03-16-05
S0124=	William R. Purce	REINVESTMENT OF SAVINGS REALIZED/ COMM. CARE.	S	Re-ref Com On Appropriations/ Base Budget	02-14-05	03-16-05
S0208=	Jeanne H. Lucas	AMEND OCCUPATIONAL THERAPY LAWS/FEE.	*SR	Ch. SL 2005-432	02-24-05	05-03-05
S0216=	Martin L. Nesbit	COORDINATION OF CHILDREN'S SERVICES/ STUDY.	S	Re-ref Com On Appropriations/ Base Budget	02-24-05	04-13-05
S0268	William R. Purce	ANIMAL EXHIBITION SANITATION/"AEDIN'S LAW".	*SR	Ch. SL 2005-191	05-25-05	06-01-05
S0326	Stan Bingham	RETIRED NURSES RETURN TO WORK.	*S	Re-ref Com On Pensions &	03-03-05	04-21-05

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
				Retirement and Aging		
[redacted]91	Jeanne H. Lucas	HOSPITAL-ACQUIRED INFECTION RATES.	S	Ref To Com On Health Care	03-07-05	
S0394=	David W. Hoyle	AUTHORIZE LICENSURE/ ANESTHESIOLOGIST ASST'S.	S	Ref To Com On Health Care	03-07-05	
S0482=	Katie G. Dorsett	INDOOR ARENA SMOKING REGULATIONS.	SR	Ch. SL 2005-239	03-10-05	03-30-05
S0489	Janet Cowell	COSMETIC ART DEFINITIONS/EXAM FACILITIES.	*S	Ref To Com On Health	03-15-05	06-01-05
S0502	William R. Purce	AMEND STAR-RATED LICENSE FOR CHILD CARE FAC.	S	Ref To Com On Health Care	03-15-05	
S0506	William R. Purce	CANCER REGISTRY.	SR	Ch. SL 2005-373	03-15-05	03-23-05
S0549=	Austin M. Allran	ABORTION-WOMAN'S RIGHT TO KNOW.	S	Ref To Com On Health Care	03-15-05	
S0572	A. B Swindell	LICENSE ASSISTED LIVING FACIL./ELDERLY.	SR	Ch. SL 2005-66	03-16-05	03-23-05
S0581	James Forrester	PRESCRIPTION MANAGEMENT PROGRAM.	S	Ref To Com On Health Care	03-16-05	
S0650	Jeanne H. Lucas	CLINICAL TRIAL RESULTS PUBLISHED.	S	Ref To Com On Health Care	03-17-05	
S0662=	William R. Purce	MED ADMINISTRATION/ UNLICENSED PERSONNEL.	S	Ref To Com On Health Care	03-17-05	
S0663	William R. Purce	ASTHMA MEDS/STUDENT SELF-ADMINISTRATION.	S	Ref To Com On Health Care	03-17-05	
S0665=	Fletcher L. Hart	PUBLIC HLTH AUTHORITIES/CO. MEDICAID BILLING.	*SR	Ch. SL 2005-459	03-17-05	05-05-05
$ [redacted]73=	**Martin L. Nesbit**	**JOBS FOR ALL ACT.**	**S**	**Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget**	**03-17-05**	
S0680	Stan Bingham	DISAPPROVAL OF CERTAIN RULES.	S	Ref To Com On Health Care	03-17-05	
S0703=	Martin L. Nesbit	RATE AND INFLATIONARY INCREASES/MH PROVIDERS.	S	Re-ref Com On Appropriations/ Base Budget	03-21-05	05-25-05
$ S0705	**Martin L. Nesbit**	**AMEND SUBSTANCE ABUSE LAWS.**	***SR**	**Ch. SL 2005-431**	**04-27-05**	**05-16-05**
S0711=	A. B Swindell	NC DENTAL BOARD/EXAMS & REAL PROPERTY.	*SR	Ch. SL 2005-366	03-21-05	04-07-05
S0740	Tony Rand	CERTIFICATE OF NEED AMENDMENTS.	*SR	Ch. SL 2005-325	03-22-05	05-31-05
S0765	William R. Purce	INCREASE AREA MH/DD/ SAS BD MEMBERSHIP.	S	Ref To Com On Health	03-22-05	03-30-05
S0768	William R. Purce	NC HEALTH CHOICE/ CONTROL UTILIZATION & COST.	*S	Ref To Com On Health Care	03-22-05	
$ S0804	**Fletcher L. Hart**	**PUBLIC HEALTH TASK FORCE/ACCRED. RECOMMEND.**	***SR**	**Ch. SL 2005-369**	**04-27-05**	**05-04-05**
S0830=	Keith Presnell	HEMOPHILIA DRUGS/	S	Ref To Com On	03-23-05	

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2005-2006 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		REMOVE SUNSET ON PRIOR AUTH.		Health Care		
[redacted]77	William R. Purce	AMEND LAWS/PRAC. OF MED./INC. CERTAIN FEES.	S	Ref to Health Care. If fav, re-ref to Finance	03-23-05	
S0942=	Scott Thomas	ESTABLISH CHILD ASSESSMENT RESPONSES.	S	Ref To Com On Health Care	03-24-05	
S0960	William R. Purce	STUDY CHILD NUTRITION SERVICES INDIR. COSTS.	*S	Ref To Com On Children, Youth and Families	03-24-05	05-12-05
S1009	Kay R. Hagan	AMEND ELECTROLYSIS PRACTICE ACT/FEES.	S	Ref to Health Care. If fav, re-ref to Finance	03-24-05	
S1020=	Malcolm Graham	RESTAURANTS/PROVIDE INFO ON USE OF PEANUTS.	S	Ref To Com On Health Care	03-24-05	
S1025=	Eleanor Kinnaird	NATUROPATHIC PHYSICIANS REGISTRATION ACT.	S	Ref To Com On Health Care	03-24-05	
S1028	Janet Cowell	STRENGTHEN LAWS/ COMPOUND'G/ ADMINISTER'G DRUG.	S	Ref To Com On Health Care	03-24-05	
S1040	Philip E. Berger	PROHIBIT HUMAN CLONING.	S	Ref To Com On Health Care	03-24-05	
S1059=	William R. Purce	PERFUSIONISTS LICENSURE.	*SR	Ch. SL 2005-267	03-24-05	05-05-05
S1072	Tony Rand	HOSPITAL LICENSE CHANGES.-AB	*S	Ref To Com On Health	03-24-05	04-13-05
$ S1074	**Tony Rand**	**FACILITY QUALITY AND SAFETY IMPROVEMENTS.**	***S**	**Ref To Com On Health**	**03-24-05**	**05-18-05**
[redacted]92	Robert Lee Hollo	NC MEDICAL BOARD MEMBERSHIP REFORMS/ REPORTS.	S	Ref To Com On Health Care	03-24-05	
S1128	Walter H. Dalton	MEDICAID: NO PREAUTH. FOR CERTAIN DRUGS.	S	Ref To Com On Health Care	03-24-05	
S1153	Bob Atwater	STATE OF THE CHILD ANNUAL REPORT.	S	Ref To Com On Health Care	03-24-05	
S1161=	Tom Apodaca	CENTRAL LISTING/MH BEDS/INVOL. COMM.	*S	Ref To Com On Health	03-24-05	05-26-05

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Senate Health Care Committee
Wednesday, February 16, 2005, 11:00 AM
643 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Presentations
Guest Speaker, Dr. Luke Bierman, Director of the Institute for Emerging Issues will speak on the 2005 Emerging Issues Forum "My Health is Your Business: Making Healthcare Work in North Carolina", and the work of the Institute on health care issues.

Other Business

Adjournment

Senate Health Care Committee
Wednesday February 16, 2005
11:00 A.M.
Room 643, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, February 16, 2005, in Room 643 of the Legislative Office Building, with nine members present. Senator Stan Bingham presided. Senator Bingham welcomed the committee members present and introduced the pages. NC Pediatric Society Residents from Duke, Chapel Hill, and Wake Forest were recognized.

Senator Bingham introduced the Guest Speaker, Dr. Luke Bierman, Director of the Institute for Emerging Issues. Dr. Bierman reported to the committee from the 20th Annual Emerging Issues Forum on the topic: "My Health is Your Business: Making Healthcare Work in North Carolina". Dr. Bierman stated that something had to be done about health care issues. He stated that health care issues are interconnected and affect not just the hospital and not just the insurer but it affects everyone. Somewhere someone has to pay. He said that working groups came up with the proposals and that there was no silver bullet and no one answer. The working groups consisted of forty people representing employers, hospitals, physicians groups, pharmaceutical and insurance companies, consumer groups and other constituencies. They met five months looking for ways to improve health care access, cost, and quality in North Carolina.

.Dr. Roland Stephen, Institute Faculty Fellow and North Carolina State Political Science Professor presented the recommendations for health care reform. Dr. Stephen stated the institute was focusing on four clusters of activities. The first issue is Expanded Access. Many kids remain uncovered, and more than half of the employees of small businesses have no insurance. This year there will be no substantial expansion of State Children's Health Insurance Program (SCHIP) and Medicaid in the budget cycle. They are looking at moving kids under five from SCHIP to Medicaid. The second one is Information Technology. Using appropriate technology reduces cost and medical errors. The third is quality. Set health care quality standards and reward health care providers for meeting the standards. The fourth is prevention. Reduce childhood obesity by promoting physical education and physical activity and more nutritious food in schools.

Steve Shore, from the NC Pediatric Society explained that a family of four making $38,000 is 200% poverty. Some families are not aware they are eligible for SCHIP. Some children are not eligible and some are not enrolled.

Senator Allran expressed the need for Medicaid not to be cut in Washington, DC. Dr. Bierman and Dr. Stephen indicated they were not lobbyist.

The meeting adjourned at 12:00 Noon.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

The Institute for Emerging Issues
North Carolina State University

The Institute for Emerging Issues is a "think and do" tank affiliated with North Carolina State University. The Institute is a catalyst for innovative public policy through its research, ideas, debate and action that encourages civic leadership in business, government and higher education. Established in 2002, the Institute is best known for organizing the annual Emerging Issues Forum but provides its expertise on many other issues in many other ways. The Institute currently focuses its programs on economic development, technology and healthcare, to make North Carolina a better place to live, work and play.

Dr. Luke Bierman is the Director of the Institute for Emerging Issues at the North Carolina State University. Trained as a lawyer and political scientist, Dr. Bierman earned a Ph.D. and M.A. in Political Science at the State University of New York at Albany, a J.D. at the Marshall Wythe School of Law of the College of William and Mary in Virginia, and a B.A. in American Political History at Colgate University. He was the founding director of the American Bar Association Justice Center. Dr. Bierman clerked for state appellate judges in New York and served as a legislative counsel to the Connecticut General Assembly Judiciary Committee. He is also an elected member of the American Law Institute.

Dr. Roland Stephen is a Faculty Fellow with the Institute for Emerging Issues where he serves as the coordinator of the Faculty Fellows Program. He also provides counsel and leadership on public policy issues addressed by the Institute, including economic development, the global economy, and the transition of North Carolina's traditional industries. An Associate Professor in the Department of Political Science and Public Administration, Dr. Stephen specializes in the area of international and comparative political economy. He has a B.A. from Cambridge University in Economics and History and a Ph.D from UCLA in Political Science.

Sara Lawrence is a Policy Analyst and Project Manager for the Institute for Emerging Issues. She works primarily on content development for the Institute's initiatives, including the annual Emerging Issues Forum and smaller public and private events across the state. Ms. Lawrence has a Master's degree in city and regional planning from UNC Chapel Hill with a concentration in economic development and a B.A. in Political Science from the University of Georgia. Prior to joining IEI, Ms. Lawrence was a program manager at the Corporation for Enterprise Development, a national non-profit organization, that promotes asset building and economic opportunity strategies.

Aaron McKethan is a Research Fellow at the Institute for Emerging Issues, focusing on health policy and regional development issues. After graduating with honors and distinction from UNC Chapel Hill, Mr. McKethan became a director for a North Carolina-based physician practice management organization. In addition to his work at the Institute, Aaron is working on a Ph.D. in Public Policy at UNC Chapel Hill, focusing on the economic importance of the growing health services industry in North Carolina.

Healthcare Statistics

- 2001 –2003 per capita spending grew at an average annual rate of 9% and the cost of premiums rose by 37%.

- 2001 – 2003 NC tied for the 7th largest increase in state uninsured rates

- 17% of North Carolinians under 65 are uninsured (1.4 million). This is higher than the national average.

- 13% of children (under 18) are uninsured (277,000)

- Number of uninsured has increased by 300,000 since 2000.

ACC Table

State	Uninsured Rate
NC	17 %
GA	16.3 %
SC	13.4 %
VA	13.3 %
TN	12.0%

Expanded Access

- Many kids remain uncovered, and more than half of the employees of small businesses have no insurance.
- No substantial expansion of SCHIP and Medicaid is likely this budget cycle.
- Recognized opportunity: Move kids under 5 from SCHIP to Medicaid (Blue Ribbon Commission recommendation #5).
- Looking for creative ways to provide access to private insurance and public programs: Small business pool with reinsurance, limited benefits Medicaid package open to small business employees, unemployed.

Hill Burton II

- Many of the state's providers, especially small and rural ones, cannot afford necessary information technology (IT).
- Using the appropriate technology reduces costs ($77 billion nationwide by one estimate) and reduces medical errors.
- Adopting IT is a federal priority.
- Multistage process coming out of the Forum: Define the scope and specifications of required IT, pursue pilot programs using federal and/or foundation money, develop creative financing through state-guaranteed loans and/or grants.

"North Carolina Best Care"

- Healthcare providers are inundated with multiple practice guidelines, making it hard to identify latest best practices.
- Create a task force, working through research hospitals and institutes, to review data and clinical practice and recommend consolidated guidelines to be distributed to practitioners.
- Work with public and private insurers to measure and incentivize adoption and evaluate outcomes.
- Explore ways to increase compensation for providers who adhere to best practices

Childhood Obesity

- Growing number of children in North Carolina who suffer from obesity.
- This leads to asthma, diabetes and other illnesses.
- Many people and organizations are attacking this issue (for example, the Health and Wellness Study Commission), these efforts need to be promoted and publicized.

The Institute for Emerging Issues is very grateful to the participants in the working groups listed below.

Walker Armfield
Policy Advisor, Office of the Governor

William Atkinson, PhD
President and CEO, WakeMed Health and Hospitals

William P. Brandon PhD, MPH
Faculty Fellow, Institute for Emerging Issues, Professor, UNC Charlotte

Barbara Morales Burke
Assistant Commissioner, NC Department of Insurance

Lanier Cansler
Deputy Secretary, NC DHHS

Christopher J. Conover
Assistant Research professor, Duke University

Keith Crisco
President, Asheboro Elastics

Leah Devlin, DDS, MPH
State Health Director, Division of Public Health, NC DHHS

Allen Feezor
Chief Planning Officer, University Health Systems of Eastern North Carolina

Marlowe Foster
President, NC Association of Health Plans

Laura I. Gerald MD, MPH
Senior Medical Consultant, Community Care of North Carolina

Patricia Garrett
Project Director, NC Pediatric Society Foundation

Dan Gerlach
Senior Policy Advisor for Fiscal Affairs, Office of the Governor

Patricia Johnston
Health Policy Consultant, N.C. Health and Wellness Trust Fund

Kenneth Lewis
Executive Director, FirstCarolinaCare, Inc.

Brian Moore
Chief, Strategic Planning, Mission Hospitals

Beverly E. Perdue
Lieutenant Governor, North Carolina

Thomas Prewitt, MD
President, Blue Ridge Surgical Group

William Pully
President, NC Hospital Association

Jack E. Rodman
President & CEO, North Carolina Business Group on Health, Inc.

Christopher J. Ruhm
Professor, UNCG

Adam Searing
Project Director, NC Health Access Coalition

Paul G. Sebo
Manager, Operations, North Carolina State Health Plan

Vandana Shah
Policy Director, NC Health and Wellness Trust Fund

Pam Silberman JD, DrPH
Vice President, North Carolina Institute of Medicine

John E. Skvarla III
Partner, Country Club of Whispering Pines

Rebecca T. Slifkin
Director, North Carolina Rural Health Research & Policy Analysis Center

Keith Smith
Senior Vice-President and General Counsel, Carolinas Healthcare

Phil Telfer
Senior Policy Advisor, Office of the Governor

Von Valletta
State President, AARP North Carolina

Tom Vitaglione
Fellow, NC Child Advocacy Institute

Chuck Willson MD
Clinical Professor of Pediatrics, ECU, President, NC Medical Society

VISITOR REGISTRATION SHEET

Senate Health Care — **February 16, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCRP
Jim Eldridge	NCHITC
Dave Richard	The Arc
Abby Emanuelson	NMSS
Butch Gunnells	NCSDA
Jennifer Sullivan	NASW-NC
	NCFPC
	NCOHHS
George Reed	NC Council of Churches
Doug Heron	NC BAR Assoc.
Dana Simpson	Smith Anderson

VISITOR REGISTRATION SHEET

Senate Health Care — **February 16, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCSA
Lu Hodges	KCLH
John Lyons	N.C. State Grange
	Allen Associates
Johnny Tillett	J Tillett Lobbying Group
JOEL MAYNARD	G. PEYTON MAYNARD & ASSOCIATES
Gary Salamido	GSK
	GSK
Garland Pierce	House Rep
Betsy Redman	Southeastern N.C. Heart Disease & Stroke Prev.
Christie Harris	Provider Link, Inc.

VISITOR REGISTRATION SHEET

Senate Health Care — **February 16, 2005**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Debbie Barnes	OSBM
Peter A. Yancy	APPCNC/FRLTC
Steve Shore	NC Pediatric Society
Brian Olsen	UNC Pediatric Resident
Jeff Anderson	UNC Pediatrics
Leah Smith	UNC Pediatrics
Jessica Fu	UNC Pediatrics
Michelle Hernandez	UNC Pediatrics
Coy Miller	WAKE FOREST PEDS
Josh Cobb	John Locke Foundation
Steve Fong	NC Pediatric Society/ Wake Forest U. School of Medicine

VISITOR REGISTRATION SHEET

Senate Health Care — **February 16, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Anita Pulley	Northwest AHEC WFU School of Medicine
Herb Clegg	NC Pediatric Society
Scott Bailey	Duke Pediatrics
Karin R Minter	Duke Pediatrics / NC Pediatric Society
Paula A. Woof.	Planned Parenthood / El Pueblo
	NCAHP

AGENDA

SENATE HEALTH & HUMAN RESOURCES COMMITTEE
February 23, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- S.B. 3, Authorize Competency Req./NC Bd. of Nursing
- S.B. 72, Expand County board of Health Membership
- S.B. 83, ADET School/Fee/Qualis. Increase

III. Other Business

IV. Adjournment

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	February 23, 2005	11:00 AM	544, LOB

The following will be considered:

	BILL NO.	SHORT TITLE	SPONSOR
•	SB3	Authorize Competency Req./NC Bd. Of Nursing	Sen. Rand
•	SB72	Expand County Board of Health Membership	Sen. Hagan
•	SB83	ADET School/Fee/Qualis. Increase	Sen. Dannelly

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

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, February 23, 2005
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, February 23, 2005, in Room 544 of the Legislative Office Building, with fourteen members 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 Senator Hagan to present her bill, S.B. 72, *Expand County Board of Health Membership* to the Committee. A Proposed Committee Substitute (PCS) was presented in place of the original bill. Senator Allran pointed out that although this is a public bill, in its present form it would affect only Guilford County. In response to a question from Senator Goodall, Senator Hagan said that this bill would require the Board of Health to add one restaurant owner member. Senator Forrester asked why the Board just didn't add another member, and Senator Hagan responded that the county attorney recommended that the number remain at eleven. Ken Conrad, president and CEO of Libby Hill Seafood Restaurant was call upon to speak. He said that this bill was requested so that the restaurant owners would have a voice on the Board. Senator Allran moved for a favorable report, unfavorable as to the original bill, favorable as to the PCS. The motion passed.

Senator Purcell introduced Dr. Charles O. Boyette, Mayor of Belhaven and past National Doctor of the Year. Dr. Boyette also has served the General Assembly many times as Doctor of the Day. With Dr. Boyette was Peter Chen, a medical student at the Bowman-Gray School of Medicine.

Senator Dannelly's bill, S.B. 83, *ADET Alcohol/Fee/Qualis. Increase*, also carried a PCS. The Committee voted to consider the PCS instead of the original bill. Senator Dannelly said that this bill came about at the recommendation of the DWI Advisory Committee and the Department of Health and Human Services. It primarily increases fees and raises the qualifications of instructors. He added that he has requested a fiscal note for the bill and that if approved, it would go to the Finance Committee. Senator Forrester asked if funds to pay the various fees would be available for indigent persons. Mr. Michael Eisen of the Department of Health and Human Services was called on to answer this question. He said that a person would have to pay the minimum of $75 on a sliding scale, but the $160 fee is non-negotiable and is required for the class and for return of the driver's license. Senator Malone asked, if an individual's livelihood depended on his/her driving, but the person could not afford the fee, what would happen. Senator Dannelly pointed out that the fees in this bill are lower that those in states already having this law. Senator Dorsett questioned as to whether an individual would be responsible for all three fees listed in Section 1. Mr. Eisen responded that all persons are responsible for the $100 assessment fee; after assessment an individual would go either to treatment for a $75 fee or to the ADET class for a fee of $160. Senator Allran pointed out that part of the fee would go to a tracking system for the program. He moved for an unfavorable report as to the original bill, favorable to the PCS. The motion passed.

The PCS for Senator Rand's bill, S.B. 3, *Authorize Competency Rea./NC Bd. of Nursing* was voted on and approved. In response to a question, Senator Rand said the bill would ensure continued competency of nurses. Polly Johnson of the Board of Nursing said that licenses are renewed every two years through random selection and that if a license had elapsed, the nurse would have to supply evidence of competency in applying for a new license. Senator Garwood moved for an unfavorable report as to the original bill, favorable as to the PCS. The motion passed.

The meeting adjourned at 11:40 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 CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, February 23, 2005

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

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

S.B. **72** Expand County Board of Health Membership.

Draft Number:	PCS75072
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, February 23, 2005

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

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

S.B. **3** Authorize Competency Req./NC Bd. of Nursing.

Draft Number:	PCS75084
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **83** ADET School/Fee/Qualifications Increase.

Draft Number:	PCS85058
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 3

Short Title:	Authorize Competency Req./NC Bd. of Nursing.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

January 27, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF NURSING TO REQUIRE ITS LICENSEES TO SUBMIT EVIDENCE OF CONTINUING COMPETENCY UPON LICENSE RENEWAL OR REINSTATEMENT.

The General Assembly of North Carolina enacts:

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

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

...

(20) Establish rules requiring a licensee to submit to the Board evidence of the licensee's continuing competence in the practice of nursing at the time of license renewal or reinstatement.

...."

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

SENATE BILL 3:
Authorize Competency Req./NC Bd. of Nursing

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Rand
Date:	February 23, 2005	**Summary by:**	Dianna Jessup
Version:	PCS S3-CSSW-1		Committee Counsel

SUMMARY: ***The bill would amend the Nursing Practice Act to permit the Board of Nursing to adopt rules requiring applicants to submit evidence of continuing competency in the practice of nursing at the time an applicant submits an application for renewal or reinstatement. The act would become effective when it becomes law. The PCS makes technical changes to terminology.***

CURRENT LAW: The practice of nursing is regulated by a Board of Nursing, which consists of 14 members. Eleven of the 14 Board members are nurses. Nurses must be licensed by the Board and must renew their licenses every two years. Reinstatement of a nurse's license can occur under three circumstances:

- If a nurse fails to renew a license on a timely basis, the nurse can apply to the Board for reinstatement of the license.
- If a nurse's license is revoked, the Board can reinstate the license if it finds that the reasons for the revocation no longer exist and that the nurse can reasonably be expected to safely and properly practice nursing.
- Retired nurses may apply for reinstatement upon satisfying any requirements the Board considers necessary to reinstate the license.

The Board approves continuing education programs for nurses. In order to approve a program, the Board must find that the program offers an educational experience designed to enhance the practice of nursing. Licensees are required to specify the amount of continuing education they have completed when renewing their licenses; however, the Board is not specifically authorized to require nurses to provide evidence of continuing competency in nursing.

BILL ANALYSIS: Senate Bill 3 would authorize the Board to adopt rules requiring applicants who are renewing their licenses or requesting reinstatement of their licenses to submit to the Board "evidence of the applicant's continuing competence in the practice of nursing." The Board would determine what constitutes "evidence of the applicant's continuing competence". As part of the Board's voluntary "Reflective Practice Approach" to continued competence in nursing, the Board has identified the following learning activities as acceptable options for nurses and may be an indication as to what the Board would consider to be "evidence of the applicant's continuing competence":

1. National certification or re-certification related to the nurse's practice role.
2. Proof of earning 30 approved contact hours of continued education related to the nurse's practice role and competency or learning needs.
3. Completion of a Board approved refresher course.
4. Completion of a minimum of three semester hours of post-licensure academic education leading to additional licensure or preparation for advanced practice in nursing.

5. Proof of earning 15 approved contact hours, related to the nurse's practice role, competency or learning needs; PLUS at least one of the following:
    - Project-completion of a nursing research project as principal investigator or co-investigator, including summary of findings.
    - Publication-authoring or co-authoring a nursing-related article, paper or text.
    - Presentation- developing and conducting a nursing continuing education presentation, evidenced by a program brochure, objectives, date and location of presentation and approximate number of attendees.
    - Active Practice-640 hours of practice within previous 2 years, with a satisfactory employer evaluation.

The act would become effective when it becomes law.

S3-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 3
PROPOSED COMMITTEE SUBSTITUTE S3-CSSW-1 [v.2]

2/21/2005 12:15:22 PM

Short Title: Authorize Competency Req./NC Bd. of Nursing. (Public)

Sponsors:

Referred to:

January 27, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF NURSING TO REQUIRE APPLICANTS TO SUBMIT EVIDENCE OF CONTINUING COMPETENCY UPON LICENSE RENEWAL OR REINSTATEMENT.

The General Assembly of North Carolina enacts:

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

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

...

(20) Adopt rules requiring an applicant to submit to the Board evidence of the applicant's continuing competence in the practice of nursing at the time of license renewal or reinstatement.

...."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 72

Short Title:	Expand County Board of Health Membership.	(Public)
Sponsors:	Senators Hagan; and Dorsett.	
Referred to:	Health Care.	

February 8, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE CERTAIN COUNTIES TO EXPAND COUNTY BOARD OF HEALTH MEMBERSHIP TO INCLUDE A RESTAURANT OWNER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-35 reads as rewritten:

"**§ 130A-35. County board of health; appointment; terms.**

(a) A county board of health shall be the policy-making, rule-making and adjudicatory body for a county health department.

(b) The members of a county board of health shall be appointed by the county board of commissioners. ~~The~~ Except as otherwise provided in subsection (j) of this section, the board shall be composed of 11 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include: one physician licensed to practice medicine in this State, one licensed dentist, one licensed optometrist, one licensed veterinarian, one registered nurse, one licensed pharmacist, one county commissioner, one professional engineer, and three representatives of the general public. All members shall be residents of the county. If there is not a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer available for appointment, an additional representative of the general public shall be appointed. If however, one of the designated professions has only one person residing in the county, the county commissioners shall have the option of appointing that person or a member of the general public.

(c) Except as provided in this subsection, members of a county board of health shall serve three-year terms. No member may serve more than three consecutive three-year terms unless the member is the only person residing in the county who represents one of the professions designated in subsection (b) of this section. The county commissioner member shall serve only as long as the member is a county commissioner. When a representative of the general public is appointed due to the unavailability of a licensed physician, a licensed dentist, a licensed optometrist, a

licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer, that member shall serve only until a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer becomes available for appointment. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a three-year term.

(d) Vacancies shall be filled for any unexpired portion of a term.

(e) A chairperson shall be elected annually by a county board of health. The local health director shall serve as secretary to the board.

(f) A majority of the members shall constitute a quorum.

(g) A member may be removed from office by the county board of commissioners for:

(1) Commission of a felony or other crime involving moral turpitude;
(2) Violation of a State law governing conflict of interest;
(3) Violation of a written policy adopted by the county board of commissioners;
(4) Habitual failure to attend meetings;
(5) Conduct that tends to bring the office into disrepute; or
(6) Failure to maintain qualifications for appointment required under subsection (b) of this section.

A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

(h) A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners.

(i) The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(j) The county board of commissioners may, by resolution adopted, expand the membership of the county board of health to include one member who is a restaurant owner and resident of the county. If a restaurant owner is not available for appointment, an additional representative of the general public may be appointed to serve until a restaurant owner becomes available for appointment. This subsection applies to counties with a population in excess of 400,000."

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

SENATE BILL 72:
County Board of Health Membership

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senators Hagan; and Dorsett
Date:	February 8, 2005	**Summary by:**	Shawn Parker
Version:	CSLN-1		Committee Staff

SUMMARY: ***Senate Bill 72 would allow the county boards of commissioners in Guilford, Mecklenburg, and Wake counties to change the membership of the county board of health to include one restaurant owner and reduce one member of the general public. The original bill would have expanded the membership to include one restaurant owner. The act would become effective when it becomes law.***

CURRENT LAW: The members of a county board of health are appointed by the county board of commissioners. The board is composed of 11 members. The composition of the board is required to reasonably reflect the population makeup of the county and must include: one physician licensed to practice medicine in this State, one licensed dentist, one licensed optometrist, one licensed veterinarian, one registered nurse, one licensed pharmacist, one county commissioner, one professional engineer, and three representatives of the general public. All members must be residents of the county. If there is not a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer available for appointment, an additional representative of the general public must be appointed. If however, one of the designated professions has only one person residing in the county, the county commissioners has the option of appointing that person or a member of the general public.

BILL ANALYSIS: Senate Bill 72 would authorize the county board of commissioners in Guilford, Mecklenburg, and Wake counties to change the membership of the county board of health by reducing the number of public member positions by one and including the position of a restaurant owner. If a restaurant owner is not available for appointment, a representative of the general public may be appointed to serve until a restaurant owner becomes available for appointment. In order to alter the membership, the board of commissioners would have to adopt a resolution.

EFFECTIVE DATE: This act would become effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 72
PROPOSED COMMITTEE SUBSTITUTE S72-CSLN-1 [v.1]

2/21/2005 11:40:43 AM

Short Title: County Board of Health Membership. (Public)

Sponsors:

Referred to:

February 8, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE CERTAIN COUNTIES TO CHANGE COUNTY BOARD OF HEALTH MEMBERSHIP TO INCLUDE A RESTAURANT OWNER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-35 reads as rewritten:

"**§ 130A-35. County board of health; appointment; terms.**

(a) A county board of health shall be the policy-making, rule-making and adjudicatory body for a county health department.

(b) The members of a county board of health shall be appointed by the county board of commissioners. The board shall be composed of 11 members. ~~The~~ Except as otherwise provided in subsection (j) of this section, the composition of the board shall reasonably reflect the population makeup of the county and shall include: one physician licensed to practice medicine in this State, one licensed dentist, one licensed optometrist, one licensed veterinarian, one registered nurse, one licensed pharmacist, one county commissioner, one professional engineer, and three representatives of the general public. All members shall be residents of the county. If there is not a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer available for appointment, an additional representative of the general public shall be appointed. If however, one of the designated professions has only one person residing in the county, the county commissioners shall have the option of appointing that person or a member of the general public.

(c) Except as provided in this subsection, members of a county board of health shall serve three-year terms. No member may serve more than three consecutive three-year terms unless the member is the only person residing in the county who represents one of the professions designated in subsection (b) of this section. The county commissioner member shall serve only as long as the member is a county commissioner. When a representative of the general public is appointed due to the

unavailability of a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer, that member shall serve only until a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer becomes available for appointment. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a three-year term.

(d) Vacancies shall be filled for any unexpired portion of a term.

(e) A chairperson shall be elected annually by a county board of health. The local health director shall serve as secretary to the board.

(f) A majority of the members shall constitute a quorum.

(g) A member may be removed from office by the county board of commissioners for:

(1) Commission of a felony or other crime involving moral turpitude;
(2) Violation of a State law governing conflict of interest;
(3) Violation of a written policy adopted by the county board of commissioners;
(4) Habitual failure to attend meetings;
(5) Conduct that tends to bring the office into disrepute; or
(6) Failure to maintain qualifications for appointment required under subsection (b) of this section.

A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

(h) A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners.

(i) The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(j) The county board of commissioners may, by resolution adopted, change the membership of the county board of health to reduce the number of public members by one and add one member who is a restaurant owner and resident of the county. If a restaurant owner is not available for appointment, a representative of the general public may be appointed to serve until a restaurant owner becomes available for appointment and is appointed. This subsection applies to counties with a population in excess of 400,000."

SECTION 2. This act is effective when it becomes law and applies to appointments to fill a vacancy in public member representation on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 83

Short Title:	ADET School/Fee/Qualis. Increase.	(Public)
Sponsors:	Senators Dannelly, Nesbitt, Allran, Lucas, Purcell; Dorsett, and Malone.	
Referred to:	Health Care.	

February 9, 2005

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR ATTENDING AN ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL, TO INCREASE THE AMOUNT REMITTED FROM THE FEE BY AN AREA FACILITY TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO PROVIDE ADET SCHOOL INSTRUCTION, TO DIRECT THE COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO MODIFY THE RULES REGARDING THE NUMBER OF INSTRUCTIONAL HOURS AND MAXIMUM ADET SCHOOL CLASS SIZE, AND TO REQUIRE THE DEPARTMENT TO ESTABLISH AN OUTCOMES EVALUATION STUDY ON THE EFFECTIVENESS OF SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY 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-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 one hundred dollars ($100). A person shall pay to a ~~treatment facility or~~ school a fee of ~~seventy five dollars ($75.00).~~one hundred sixty dollars ($160.00). A person shall pay to a treatment facility 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%)~~ ten percent (10%) 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 2. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(d1) Persons Authorized to Provide Instruction. – Beginning January 1, 2009, individuals who provide ADET school instruction as a Department-authorized ADETS instructor must have at least one of the following qualifications:

(1) Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

(3) Certified Substance Abuse Prevention Consultant (CSAPC), as defined by the Commission."

SECTION 3. The Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall revise its rules regarding the number of instructional program hours and the class size for ADET schools. The minimum program hours of instruction shall not be less than 16 hours. The maximum class size shall not be more than 20 participants.

SECTION 4. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(j) The Department shall establish an outcomes evaluation study on the effectiveness of substance abuse services provided to persons who obtain a certificate of completion under G.S. 20-17.6 as a condition for restoration of a drivers license. The findings of the study shall be reported every two years to the Joint Legislative Commission on Governmental Operations. The Department shall submit an initial report on the findings of the study to the Commission no later than December 31, 2007, and shall submit a report to the Commission every two years following that date."

SECTION 5. Section 1 becomes effective when the rules adopted under Section 3 of this act become effective and shall apply to fees charged for ADET school instruction that commences on or after that date. The remainder of this act is effective when it becomes law.

SENATE BILL 83:
ADET School/Fee/Qualifs. Increase.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Dannelly
Date:	February 9, 2005	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***The bill would increase the fee charged for an alcohol and drug education traffic (ADET) school, increase the qualifications for persons providing ADET instruction, direct the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services (Commission) to revise its rules regarding the amount of ADET instructional time and maximum class size, and direct the Department of Health and Human Services (Department) to study the effectiveness of substance abuse services provided through ADET courses and report its findings to the Commission every two years. The fee increase would become effective when the revised rules governing class size and hours of instruction become effective. The ADET instructor qualifications would become effective on January 1, 2009. The Department study of ADET course effectiveness would become effective when the bill becomes law. The Proposed Committee Substitute modifies the language of the bill to ensure that all facilities authorized to offer ADET courses are required to remit to the Department the statutory amount of each fee paid for a person attending ADET courses.***

CURRENT LAW: A person is guilty of impaired driving (DWI) if he or she drives a motor vehicle on any public vehicular area while under the influence of an impairing substance or with a blood alcohol concentration (BAC) of 0.08 or more[1]. Upon conviction of a DWI offense, the Department of Motor Vehicles (DMV) must immediately revoke the offender's drivers license[2]. DMV may not restore the license unless it receives a certificate of completion indicating that the offender has undergone a substance abuse assessment and either completed an ADET school or a substance abuse treatment program[3].

An offender is eligible to attend an ADET school if the offender's substance abuse assessment does not identify a substance abuse disability, the offender has no prior DWI convictions and the offender had a BAC of 0.14 or less at the time of the offense. The fee for attending ADET school is $75. (The fee for substance abuse treatment depends upon the level and extent of treatment provided, with the minimum fee being $75.)[4]

The curriculum for ADET school is established by the Commission. It consists of not less than 10 hours of instruction to be delivered in class sessions that may not exceed 3 hours in length. The maximum class size is 35 persons. In order to be certified to provide ADET school instruction a person must be a high school graduate (or equivalent); have a working knowledge of alcohol, other drugs and traffic safety issues; demonstrate skills by teaching all aspects of ADET classes; and apply to the Division of MH/DD/SAS – DWI Services for certification[5].

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[1] G.S. 20-138.1.
[2] G.S. 20-17(a).
[3] G.S. 20-17.6.
[4] G.S. 122C-142.1(f) and G.S. 122C-146.
[5] 10A NCAC 27G.3801.

BILL ANALYSIS:

Section 1 would amend G.S. 122C-142.1(f) to increase the ADET school fee from $75 to $160. The fee paid to treatment facilities would remain $75. This section would increase the amount facilities remit to the Department of Health and Human Services from 5% to 10% of fees paid and would ensure that all facilities authorized by the Department to offer ADET courses are required to remit to the Department the statutory amount (10%) of each fee paid for a person attending ADET courses.

Section 2 would amend G.S. 122C-142.1 by creating a new subsection regarding the qualifications for persons providing ADET school instruction. Beginning January 1, 2009, all Department-authorized ADET instructors would have to be either a Certified Substance Abuse Counselor (CSAC), a Certified Clinical Addiction Specialist (CCAS), or a Certified Substance Abuse Prevention Consultant (CSAPC).

Section 3 would direct the Commission to revise its rules regarding ADET school instructional time and class size. The minimum program hours must not be less than 16 hours (an increase of at least 6 hours over the current minimum). The maximum class size shall not be more than 20 persons (a decrease of at least 15 students from the current maximum).

Section 4 would direct the Department to establish an outcomes evaluation study on the effectiveness of substance abuse services provided through ADET courses to persons who obtain a certificate of completion as a condition for restoration of a drivers license. The Department must submit its first report on the findings of the study to the Commission no later than December 31, 2007 and submit a new report to the Commission every two years following that date.

BACKGROUND: In 2003, the General Assembly directed the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) to study a number of issues related to the substance abuse assessments required under G.S. 122C-142.1. In 2004, the LOC recommended that the substance abuse assessment fee be increased from $50 to $100 and that certain qualifications be required of persons who conduct the assessments. The LOC also recommended that there should be further study regarding the certification requirements for persons conducting ADET schools and the adequacy of the fee paid to the school. The General Assembly adopted the assessment fee and assessor qualification changes and charged the LOC with the additional study. S.L. 2004-197. This bill draft reflects the recommendations of the LOC on these issues.

Effective Dates: The fee increase would become effective when the revised rules become effective and would apply to ADET courses commenced on or after that date. The ADET school instructor qualifications would become effective January 1, 2009. The Department study of ADET course effectiveness would become effective when the bill becomes law with a first report to the Commission due no later than December 31, 2007.

Bill Summary based in large part upon prior work of Kory Goldsmith, Senior Staff Attorney, Research Division.

SB83-SMSS-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 83
PROPOSED COMMITTEE SUBSTITUTE S83-CSSS-1 [v.4]

2/22/2005 5:55:24 PM

Short Title: ADET School/Fee/Qualifs. Increase. (Public)

Sponsors:

Referred to:

February 9, 2005

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR ATTENDING AN ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL, TO INCREASE THE AMOUNT REMITTED FROM THE FEE BY A FACILITY TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO PROVIDE ADET SCHOOL INSTRUCTION, TO DIRECT THE COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO MODIFY THE RULES REGARDING THE NUMBER OF INSTRUCTIONAL HOURS AND MAXIMUM ADET SCHOOL CLASS SIZE, AND TO REQUIRE THE DEPARTMENT TO ESTABLISH AN OUTCOMES EVALUATION STUDY ON THE EFFECTIVENESS OF SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY 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-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 one hundred dollars ($100). A person shall pay to a ~~treatment facility or~~ school a fee of ~~seventy five dollars ($75.00).~~one hundred sixty dollars ($160.00). A person shall pay to a treatment facility 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.

A ~~An area~~ facility shall remit to the Department ~~five percent (5%)~~ ten percent (10%) 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 2. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(d1) Persons Authorized to Provide Instruction. – individuals who provide ADET school instruction as a Department-authorized ADETS instructor must have at least one of the following qualifications:

(1) Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

(3) Certified Substance Abuse Prevention Consultant (CSAPC), as defined by the Commission."

SECTION 3. The Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall revise its rules regarding the number of instructional program hours and the class size for ADET schools. The minimum program hours of instruction shall not be less than 16 hours. The maximum class size shall not be more than 20 participants.

SECTION 4(a). G.S. 122C-142.1 is amended by adding a new subsection to read:

"(j) The Department shall establish an outcomes evaluation study on the effectiveness of substance abuse services provided to persons who obtain a certificate of completion under G.S. 20-17.6 as a condition for restoration of a drivers license. The findings of the study shall be reported every two years to the Joint Legislative Commission on Governmental Operations."

SECTION 4(b). The Department shall submit an initial report on the findings of the study established under Section 4(a) of this act to the Commission no later than December 31, 2007.

SECTION 5. Section 1 becomes effective when the rules adopted under Section 3 of this act become effective and shall apply to fees charged for ADET school instruction that commences on or after that date. Section 2 becomes effective on January 1, 2009. The remainder of this act is effective when it becomes law.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — February 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lee Hodge	KCCH
Johanna Reese	DENR
Mildred Spearman	NCDOC
Jenny Matthews	UNC-CH School of Law
Ken Melton	DOR.
John McMillan	NFIB
Butch Dunnell	NCSDA
Chad Boyd MD	Dr of Doyen Gen Assn
Bill Welch	NCAE
W H Potter Jr	NCPTA & NCDC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — February 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner Spruill LLP
Sarla McKenney	DHHS
Lattie Bates	ADCHC
Deborah Burnette	NCALHD
James Brown	Institute of Govt
Sally Johnson	NC Board of Nursing
Joanne Stevens	Nursing
Jimmy Hicks, CRNA/MSN	Certified Registered Nurse Anesthetist.
Roger Bone	Bone and Assoc.
Stacy Flannery	NCHCFA
Barbara Carlson	BSCGR
Lon Walker	NCALTCE

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — February 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
KEN CONRAD	LIBBY HILL SEAFOOD RESTAURANTS, INC
X John Bowdish	AstraZeneca
Linda Bennett	UNCW Student Nurse "Nurse of the Day"
[signature]	NCRA
Suzanne Beasley	SEANC
Jason Reynolds	DHHS - DMH
Michael Eisen	DHHS - DMH
Barbara Stancil	Nurse of the Day 7750 NC 222 W Icenly NC 27542
[signature]	[signature]
[signature]	Bone & Asso.
[signature]	NCAHP
John Lyons	NC State Grange
Hal Miller	NCACCT

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — February 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NMRS
[signature]	DPH
Stephanie Twitty	Office Minority Health & Health Disparities
Alfredia Williamson	Americorps Member Off. of Minority Health, Americorps Mbr.
Jackie Sweet White	Office of Minority Health, Americorps Member

Senate Health Care Committee
Wednesday, March 9, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 45	**Accessible Electronic Info Act/Blind/Disabl'd.**	**Senator Dorsett**

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, March 10, 2004

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

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

S.B. **45** Accessible Electronic Info Act/Blind/Disabl'd.

Draft Number:	PCS35110
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, March 9, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, March 9, 2005, in Room 544 of the Legislative Office Building, with fourteen members present, Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator William R. Purcell, Co-Chairs, welcomed the committee members present and introduced the pages and our new research staff attorney, Ben Popkins. AARP Members were recognized.

Senator Bingham introduced Senator Dorsett to present Senate Bill 45, ***Accessible Electronic Info Act/Blind/Disabl'd.*** A motion to adopt the PCS for discussion was passed. Senator Dorsett stated the bill was to establish an accessible electronic information service for the blind and disabled and to appropriate the funds in the amount of seventy five thousand dollars. NewsLine for the Blind provides the service, which is part of the National Federation of the Blind. NewsLine is an automated dial-in newspaper service where the user can listen to the daily newspaper on a touch-tone telephone. The users can call a local number and then they are connected to the center in Baltimore, Maryland. Every morning newspapers are submitted and the text for that day is loaded onto the computer. This service was first started in 1994 in Baltimore and fully funded by the Federal Government. It did not come to NC until the late 1990's. Senator Bingham pointed out; the bill had a sequential referral to Appropriation/Base Budge. Senator Lucus asked if any blind person had access to this and if there was a charge to the user. Senator Dorsett stated that any blind or disabled persons were eligible with no cost to the user. Senator Lucus asked how would they know about it. Gary Ray, employed with The Library for the Blind but today representing The National Federation for the Blind, stated that the NewsLine service is advertised through outlets that reach the blind and disabled of NC. Senator Rand asked about the definition of Blind and Disabled Persons as those individuals who are eligible for library loan services pursuant to 36 C.F.R. § 701.10(b) wanting to know if that is a broad definition. Mr. Ray stated it is a broad definition and that anyone who cannot, because of a visual or physical disability use regular print, as being eligible. Senator Rand wanted to make sure it would cover any one needing the service. Senator Goodall asked about the fifteen hundred currently using this service and how much it would expand with the new allocation of money. Mr. Ray feels like it could go as high as four times that amount and feels the allocation will cover any growth in the foreseeable future. Senator Berger asked why do we need the state to provide the resources to expand. Senator Dorsett stated the current funding which is a part of the DHHS budget is not a line item. It was left over money. Senator Kinnaird asked how the Radio Service that reads the newspaper ties into this. Mr. Ray explained the Radio Reading Service. After discussion on how NewsLine operates, Senator Rand made a motion unfavorable as to bill, but favorable as to the Proposed Committee Substitute with a sequential referral to Appropriation/Base Budget. The motion passed.

The meeting adjourned at 11:20 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

S 1

SENATE BILL 45

Short Title:	Accessible Electronic Info Act/Blind/Disabl'd.	(Public)
Sponsors:	Senators Dorsett; Albertson, Dannelly, Graham, Holloman, Jenkins, Kinnaird, Lucas, Malone, and Purcell.	
Referred to:	Health Care.	

February 3, 2005

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, which 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 Services.

(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) 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-five thousand dollars ($75,000) for the 2005-2006 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, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 45
PROPOSED COMMITTEE SUBSTITUTE S45-CSSW-5 [v.7]

3/8/2005 9:03:05 AM

Short Title: Accessible Electronic Info Act/Blind/Disabl'd. (Public)

Sponsors:

Referred to:

February 3, 2005

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. Chapter 168 of the General Statutes is amended by adding a new article to read:

"ARTICLE 4.

"Accessible Electronic Information Act.

"**§ 168-30. Short title and findings.**

(a) Short Title. – This article 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, which 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 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 blind and disabled persons 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, 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 persons for access to information that is otherwise available in print, reducing isolation and supporting full integration and equal access for these persons."

"**§ 168-31. Definitions.**

The following definitions apply in this section:

(a) Accessible electronic information service. – A service where news and other timely information, including newspapers, is provided to blind and disabled persons 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.

(b) 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).

(c) Director. – The Director of the Division of Services for the Blind in the Department of Health and Human Services.

(d) Division. – The Division of Services for the Blind in the Department of Health and Human Services.

(e) Qualified entity. – An agency, instrumentality, or political subdivision of the State or a nonprofit organization that:

1. Provides interstate access for blind and disabled persons to read daily newspapers by producing audio editions by computer.
2. Provides a means of program administration or reader registration on the Internet."

"**§ 168-32. Administration of service.**

The Division shall establish, operate, promote, and administer a statewide accessible electronic information service. The Director shall enter into an agreement with a

qualified entity to provide an accessible electronic information service for blind and disabled persons. The Division shall plan for continuation of the service from year to year and maximize 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."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of seventy-five thousand dollars ($75,000) for the 2005-2006 fiscal year to be used by the Division of Services for the Blind of the Department of Health and Human Services to establish an accessible electronic information service for blind and disabled persons in this State.

SECTION 3. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 45
PROPOSED COMMITTEE SUBSTITUTE S45-PCS35110-SW-5

Short Title: Accessible Electronic Info Act/Blind/Disabl'd. (Public)

Sponsors:

Referred to:

February 3, 2005

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. Chapter 168 of the General Statutes is amended by adding a new article to read:

"Article 4.

"Accessible Electronic Information Act.

"**§ 168-30. Short title and findings.**

(a) Short Title. – This article 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, which 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 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 blind and disabled persons 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, 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 persons for access to information that is otherwise available in print, reducing isolation and supporting full integration and equal access for these persons.

"**§ 168-31. 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 blind and disabled persons 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 North Carolina 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 Services.

(4) Division. – The Division of Services for the Blind in the Department of Health and Human Services.

(5) Qualified entity. – An agency, instrumentality, or political subdivision of the State or a nonprofit organization that:

a. Provides interstate access for blind and disabled persons to read daily newspapers by producing audio editions by computer.

b. Provides a means of program administration or reader registration on the Internet.

"**§ 168-32. Administration of service.**

The Division shall establish, operate, promote, and administer a statewide accessible electronic information service. The Director shall enter into an agreement with a

qualified entity to provide an accessible electronic information service for blind and disabled persons. The Division shall plan for continuation of the service from year to year and maximize 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."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of seventy-five thousand dollars ($75,000) for the 2005-2006 fiscal year to be used by the Division of Services for the Blind of the Department of Health and Human Services to establish an accessible electronic information service for blind and disabled persons in this State.

SECTION 3. This act becomes effective July 1, 2005.

SENATE BILL 45:
Accessible Electronic Info Act/Blind/Disabled

BILL AN. LYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Dorsett
Date:	March 9, 2005	**Summary by:**	Dianna Jessup
Version:	PCS S45-CSSW-5		Committee Counsel

SUMMARY: ***Senate Bill 45 would establish in statute an accessible electronic information service for blind and disabled persons. The act would become effective July 1, 2005.***

The PCS establishes the program in Chapter 168, the Handicapped Persons chapter, instead of the Utilities chapter, and makes technical changes.

CURRENT LAW AND BACKGROUND: The Library of Congress provides books in Braille, on sound reproduction recordings, and other forms through its National Library Service for the Blind and Physically Handicapped. Libraries designated by the Librarian of Congress serve as local or regional centers for the direct loan of books, reproducers, or other specialized material to eligible readers in specific geographic areas. However, daily newspapers are not offered.

The North Carolina Library for the Blind and Physically Handicapped (NCLBPH) is part of the network of regional libraries operated by the Library of Congress National Library Service for the Blind and Physically Handicapped and is part of the State Library of North Carolina. The NCLBPH is a public library that circulates books and magazines especially made for persons who cannot use regular printed material because of a visual or physical disability. Daily newspapers are currently not offered as part of the NCLBPH's services. A person who wants to access the materials in the NCLBPH must submit an application signed by a "competent authority" who confirms the person's visual disability or physical limitation. A "competent authority" is defined to include doctors of medicine and osteopathy; ophthalmologists; optometrists; registered nurses; therapists; or professional staff of hospitals, institutions, and public or welfare agencies. Use of the NCLBPH is free.

NewsLine for the Blind is a service provided by the National Federation of the Blind that enables blind and visually impaired people to access national and local newspapers through touch-tone telephones. To be included in the service, states must be funded. Currently, more than 2,000 North Carolina residents have signed up for this service.

BILL ANALYSIS: Senate Bill 45 would establish, in statute, a statewide accessible electronic information service, which would be a service where news and other timely information, including newspapers, would be provided to certain blind and disabled persons 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. NewsLine could provide this service, which is not currently available to North Carolina residents through any other source. The Division of Services for the Blind in the Department of Health and Human Services would be responsible for administering the service, planning for its continuation from year to year, and maximizing use of federal and other funds to support the service. The Director of the Division would enter into an agreement with a "qualified entity" (defined in the statute) to provide the service. "Blind and disabled persons" would be defined as 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 federal regulations. Federal regulations define those persons as:

- 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.
- Persons whose visual disability, with correction and regardless of optical measurement, is certified by competent authority as preventing the reading of standard printed material.
- Persons certified by competent authority as unable to read or unable to use standard printed material as a result of physical limitations.
- 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.

S45-SMSW-001

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **March 9, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julie Reynolds	Student CRNA from Wake Forest Univ. Med Ctr
CHERYL STRAUB, SRNA	Wake Forest University Baptist Medical Center Medical Center Blvd. Winston-Salem, NC 27103
Chris Connell	CRNA - student from WFUBMC
Bryan Lee	CRNA Student WFUBMC Winston Salem NC
Heather Baker	Raleigh School of Nurse Anesthesia
Jones Darnell	CRNA Raleigh School of Nurse Anesthesia 23 Sunnybrook Rd Suite 163 Raleigh, NC 27610
Ted Ryburn	UNC Law School
Scott Mace	Student 7804 Harps Mill Rd Raleigh, NC 27615
Nancy Benton-Mace	CRNA 7804 Harps Mill Rd Raleigh 27615
Robin Schaefer	CRNA Craven Regional Medical Center 300 Meridian Ct New Bern, NC 28562
Catherine L'Heureux	CRNA 10519 Neland St. Raleigh, NC 27614

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **March 9, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Henry Hutaff	Coca Cola
Diane D. Fatch	AARP
Ezra L. Wilson	AARP
Helen Columbus	AARP
Cecil Columbus	AARP
Eldica Cyrus	AARP
Steve Beffenmyer	CRVA – Rutherfordton NC.
WALTER SHEARER	Certified Registered Nurse Anesthetist- Rutherfordton 1811 Capital Blvd, N.C.
GARY RAY	Library for the Blind-
BRIAN LEWIS	Covenant with NC's Children
Charles Memrick	AARP South Iredell Chapter

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **March 9, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nancy Shadlick	CRNA - 204 Fulham Place, Raleigh NC 27615
Sharon Pearce	CRNA 1366 Beaver Nursery Rd. Lexington NC 27292
Dan Lewis	CRNA 4969 Lochraven Dr. Winston-Salem NC 27104
Mark Schantz II	CRNA student 1111 Boxwood Dr Durham NC 27713
Marlowe Foster	NCAHP 3820 Merton Drive Suite 101 27609

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **March 9, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne LaFollette - Consultant	AARP
Joe McClees	McClees Consulting

AGENDA

SENATE HEALTH & HUMAN RESOURCES COMMITTEE
March 16, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered:**

- **SB 120. Expand Medicaid Eligibility to Children/200%**
- **S.B. 124, Reinvestment of Savings Realized/Comm. Care**

III. **Other Business**

IV. **Adjournment**

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

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

Wednesday, March 16, 2005

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

FAVORABLE

S.B. **120** Expand Medicaid Eligibility to Children/200%.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

S.B. **124** Reinvestment of Savings Realized/Comm. Care.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, March 16, 2005
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 16, 2005, in Room 544 of the Legislative Office Building, with ten members present. Senator William R. Purcell, Co-Chair, presided, and began by introducing medical and pediatric residents from East Carolina University, School of Medicine. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell turned the meeting over to Senator Bingham so that he could present his bill, SB 120, *Expand Medicaid Eligibility to Children/200%.* Basically, the bill raises the level of children covered by Medicaid from ages zero to six up to 200% of the federal poverty level. Under this bill the counties are held harmless and cost will be paid by Health Choice funds and federal funds. He called on Dr. Peter Morris, President of the North Carolina Pediatric Society, who spoke in favor of this bill since more children would be receiving medical care, even though this would result in lower reimbursement rates for pediatricians. Mr. Roland Stevens, Faculty Fellow at the Institute for Emerging Issues, also endorsed the bill, pointing out that there is a clear connection between healthy children and children who do well in schools. Senator Forrester noted that not very many dentists participate in Medicaid patients, and asked how many dentists in North Carolina are doing so. Ben Popkin, Research staff, said that he did not have that information at hand, and would provide it. Senator Lucas asked, regarding expansion, what this bill would do in numbers. Mr. Popkin answered that savings of $1.7M would occur the first year, with a savings of about $100 per year for about 16,000 older children, and it would allow additional savings each year. Senator Purcell pointed out that this would allow more children to be covered under Health Choice. Senator Hoyle asked if a fiscal note would be required. Mr. Popkin said that staff had discussed that, and one may be required if the bill went on to the Appropriations Committee. Senator Bingham asked about the possibility of cuts in federal Medicaid money. Mr. Popkin said that that possibility has been discussed, but it is unknown at this time. Senator Forrester moved for a favorable report, the bill passed and was referred to the Appropriations Committee.

Senator Purcell brought up SB 124, *Reinvestment of Savings Realized/Comm. Care.* He explained that Community Care of North Carolina is based on community care and disease management, making sure that all patients have a primary care physician in order that expensive emergency and hospital care could be avoided as much as possible. Savings could be realized, to better serve people with special needs. Senator Lucas asked where money originates. Mr. Popkin said that the money comes from Medicaid funding, a match of federal and state funds. In endorsing this bill, Dr. Morris said that when children are shifted from standard Medicaid into community care, savings are achieved in terms of decreased emergency room utilization, hospitalization and improved use of preventive care. Savings estimated as much as $60M in 2003 could be reinvested, such as in indigent care. Senator Lucas asked who would make the determination as to how savings that accrued would be used. Senator Purcell said that DHHS would include that in the methodology to be developed, that the money would be included in the budget of the Division of Medical Systems. Senator Dannelly moved for a favorable report. The bill passed and was referred to the Appropriations Committee.

The meeting adjourned at 11:30 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 2005

S 3

SENATE BILL 120
Corrected Copy 2/15/05
Corrected Copy 2/15/05

Short Title:	Expand Medicaid Eligibility to Children/200%.	(Public)
Sponsors:	Senators Purcell, Dannelly, Hartsell; Albertson, Atwater, Bingham, Boseman, Dorsett, Forrester, Garwood, Holloman, Jenkins, Kerr, Kinnaird, Lucas, Malone, Rand, Snow, Soles, and Swindell.	
Referred to:	Health Care.	

February 14, 2005

A BILL TO BE ENTITLED

AN ACT TO EXPAND MEDICAID COVERAGE TO CHILDREN AGE BIRTH THROUGH FIVE YEARS WITH FAMILY INCOMES EQUAL TO OR LESS THAN TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LEVEL, AND TO USE NC HEALTH CHOICE STATE AND FEDERAL FUNDS TO FUND THE EXPANSION, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall provide coverage under the State Medical Assistance Program to:

(1) Infants under the age of one year whose family income is above one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level; and

(2) Children age one year through five years whose family income is above one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal poverty level.

Coverage under this section for infants and children age birth to five years shall be paid for from federal funds received under Title XXI of the Social Security Act, and State matching funds, to implement NC Health Choice under Article 8 of Chapter 108A of the General Statutes.

SECTION 2.(a) G.S. 108A-70.21(a)(1) reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:

a. Be under the age of 19;

b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;

c. Be uninsured;

d. ~~Be in a family that meets the following family income requirements:~~ Be age six years through eighteen years and be in a family whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;

~~1. Infants under the age of one year whose family income is from one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level;~~

~~2. Children age one year through five years whose family income is above one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal poverty level; and~~

~~3. Children age six years through eighteen years whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;~~

e. Be a resident of this State and eligible under federal law; and

f. Have paid the Program enrollment fee required under this Part."

SECTION 2.(b) G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, including optional prepaid plans. Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, ninety percent (90%) of the average wholesale price for the prescription drug or the amounts published by the Centers for Medicare and Medicaid Services plus a dispensing fee of five dollars and sixty cents ($5.60) per prescription for generic drugs and four dollars ($4.00) per prescription for brand name drugs. All other health care providers providing services to Program enrollees shall accept as payment in full for services rendered the maximum allowable charges under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan for services less any copayments assessed to enrollees under this Part. No child enrolled in the Plan's self-insured indemnity program shall be required by the Plan to change health care providers as a result of being enrolled in the Program.

In addition to the benefits provided under the Plan, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, fluoride applications twice during a 12-month period, fluoride varnish, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services under this subsection that are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that do not meet the standards accepted by the American Dental Association.

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. Optical services, supplies, and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories. Eyeglass lenses are limited to single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to those made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval of the Plan. Upon prior approval by the Plan, refractions may be covered more often than once every 12 months.

(3) Hearing: Auditory diagnostic testing services and hearing aids and accessories when provided by a licensed or certified audiologist, otolaryngologist, or other hearing aid specialist approved by the Plan. Prior approval of the Plan is required for hearing aids, accessories, earmolds, repairs, loaners, and rental aids.

~~The Department may provide services to children aged birth through five years enrolled in the Program through the State Medical Assistance managed care program. Services provided through the managed care program shall be paid from Program funds.~~"

SECTION 3. This act becomes effective July 1, 2005.

SENATE BILL 120:
Expand Medicaid Eligibility to Children/200%.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Purcell
Date:	March 16, 2005	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 120 would expand Medicaid coverage to children age birth through five years with family incomes equal to or less than two hundred percent of the federal poverty level. The bill would call for the use of NC Health Choice funds (a combination of federal funds and State matching funds) to pay for this expanded coverage. The act would become effective July 1, 2005.***

CURRENT LAW: Medicaid provides health care coverage to children whose family incomes fall below certain threshold limits. The income eligibility threshold varies, based on the age of the child. Under current law, coverage is provided for infants under the age of one year whose family income is up to 185% of the Federal Poverty Level (FPL); for children aged one year through five years whose family income is up to 133% of the FPL; and for children aged six years through eighteen years old whose family income is up to 100% of the FPL. The recently released 2005 Federal Poverty Guidelines set these threshold income levels (for a family of four) at $35,798, $25,736, and $19,350, respectively[1].

The North Carolina Health Choice Program (NC Health Choice) is one of the State Children's Health Insurance Programs (SCHIP) authorized by Congress as part of the Balanced Budget Act of 1997. NC Health Choice provides health benefits for children who are uninsured, ineligible for Medicaid and whose family income is up to 200% of the FPL (currently $38,700 per year for a family of four). NC Health Choice provides health coverage to infants under the age of one year whose family income is between 185% and 200% of the FPL; to children aged one year through five years whose family income is between 133% and 200% of the FPL; and to children aged six years through eighteen years old whose family income is between 100% and 200% of the FPL. NC Health Choice is funded by a combination of federal and State funds with the federal government paying just over 75% of the total $202.1 million program expenditures in 2003-04 (State share was $49.5 million). Current enrollment figures for NC Health Choice show approximately 125,000 children in the program.

BILL ANALYSIS: Senate Bill 120 would expand Medicaid coverage by raising the family income threshold limits for children birth through age five to 200% of the FPL. An estimated 20,000 children in this age range would shift from coverage under NC Health Choice to coverage under Medicaid. A 2003 analysis by the Cecil G. Sheps Center for Health Services Research estimated savings for providing care to children birth through age five in Medicaid rather than NC Health Choice at approximately $1.7 million in SFY04 and up to $7.4 million in SFY07[2]. The cost of providing care to these additional Medicaid children would be paid by a combination of federal funds – paid at a higher federal 'enhanced SCHIP match rate' of 15% over the regular Medicaid rate of approximately 62.5% – and State matching funds. The bill would hold counties harmless for the cost of providing coverage for these additional Medicaid enrollees.

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[1] *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

[2] NC Health Choice: 2003 – Report of the North Carolina Institute of Medicine Task Force on the NC Health Choice Program, Table 8: Medicaid Payment Levels for Children Birth through Five, p. 29.

BACKGROUND: In February 2003, the NC Institute of Medicine Task Force on the NC Health Choice Program recommended that the General Assembly enact legislation to move the approximately 20,000 NC Health Choice children from birth through age five with family incomes up to 200% FPL into the Medicaid program. This Task Force recommendation was intended to enhance the care of the younger children now covered by NC Health Choice at a lower cost than currently incurred. The North Carolina Blue Ribbon Commission on Medicaid Reform repeated this recommendation in its Final Report to the 2005 General Assembly, adding that counties should be held harmless for the costs of moving children into the Medicaid program[3]. Counties currently pay 15% of the State share of Medicaid expenditures, which amounts to approximately 5.6% of total Medicaid costs.

Lower per child Medicaid costs (estimated SFY04 health coverage costs of $102.20 per child in Medicaid versus $153.72 in NC Health Choice[4]) would provide health coverage to those children birth though five years currently covered by NC Health Choice at lower cost than is currently the case. The savings produced by this shift to lower cost care could be used to offset the cost of providing care to additional children in the six through eighteen year-old range through the NC Health Choice Program.

S120-SMSS-001

[3] Blue Ribbon Commission on Medicaid Reform – Final Report to the 2005 General Assembly of North Carolina, p. 12.
[4] NC Health Choice: 2003 – Report of the North Carolina Institute of Medicine Task Force on the NC Health Choice Program, p. 27.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 124

Short Title:	Reinvestment of Savings Realized/Comm. Care.	(Public)
Sponsors:	Senators Purcell, Dannelly, Hartsell; Albertson, Allran, Atwater, Bingham, Boseman, Dorsett, Forrester, Garwood, Holloman, Jenkins, Kerr, Kinnaird, Lucas, Malone, Soles, and Swindell.	
Referred to:	Health Care.	

February 14, 2005

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO DEVELOP A METHODOLOGY FOR REINVESTING IN THE COMMUNITY SAVINGS REALIZED FROM THE COMMUNITY CARE OF NORTH CAROLINA PROGRAM, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall develop and implement a methodology for reinvesting savings realized from the Community Care of North Carolina Program back into the community. The Department of Health and Human Services shall report on the methodology not later than January 1, 2006, to 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.

SECTION 2. This act becomes effective July 1, 2005.

SENATE BILL 124:
Reinvestment of Savings Realized/Comm. Care.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Purcell
Date:	March 16, 2005	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 124 would direct the Division of Medical Assistance of the Department of Health and Human Services to develop and implement a methodology for reinvesting savings realized from the Community Care of North Carolina Program back into the community to provide care to the uninsured or underinsured.***

BILL ANALYSIS: Senate Bill 124 would direct the Division of Medical Assistance to follow the recommendation of the North Carolina Blue Ribbon Commission on Medicaid Reform by developing a methodology for reinvesting in the community savings realized from the Community Care of North Carolina Program. The Department of Health and Human Services would be required to report on the methodology developed and implemented by January 1, 2006.

This act would become effective July 1, 2005.

BACKGROUND: Community Care of North Carolina is a non-profit organization comprised of safety net providers managing the care of Medicaid enrollees. Thirteen community health networks with more than 3,000 physicians across the State work with local health departments, hospitals and social service agencies to manage care of over 590,000 Medicaid enrollees. The Community Care program works with community providers, keeps funds local and is estimated to have realized a savings of approximately $60 million in fiscal year 2003.

Recommendation number seven of the North Carolina Blue Ribbon Commission on Medicaid Reform's Final Report to the 2005 General Assembly calls for the Division of Medical Assistance to explore methods of reinvesting savings realized by the Community Care of North Carolina Program back into the community as a means of strengthening the safety net to better serve the uninsured in the state.

S124-SMSS-001

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 16, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tim Barlow	Wake Forest University Baptist Medical Center – Nurse Anesthesia Program
Christopher Hazen	Wake Forest University Baptist Medical Center - Nurse Anesthesia
Eric Butler	Wake Forest University Baptist Medical Center - Nurse Anesthesia Program
HUGH TILSON	NCHA
Jeffrey Simms	DHHS
Audra Headley	UNCC/CMC Nurse Anesthesia Program
Kristin Skinner	UNCC/Carolinas Medical Center Nurse Anesthesia Program
Paula Williams	UNCC/CMC Nurse Anesthesia Program
Katherine Stubbs	UNCC/CMC Nurse anesthesia Program
Brian Lewis	Covenant w/ NC's Children
Anne Winn	

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 16, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Heather Diefler	Carteret Co Schools
Gaie Pleant	Onslow Co. Schools
Donna Lynch	Onslow Co. Schools
Emmett Floyd	East Carolina Univ.
Carol White	Nash-Rocky Mount schools
Peyton Maynard	
Stacy Flannery	NCHCFA
Lyn Wilson	NCANTCF
Barbara Canales	BSCGR
Ann Lore	DUHS
Bryan Lee	WFUBMC - Nurse Anesthesia
Brett Van Damme	WFUBMC - Nurse Anesthesia
Andy Wright	WFUBMC — Nurse Anesthesia

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 16, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peter J Morris MD MPH	NC Pediatric Society 1100 W Forest Rd Ral NC
Steve Shore	NC Pediatric Society
Julie Strickland	Peds Resident - ECU - Greenville
Jeff Anderson	UNC - pedi resident
Bernie Sy	ECU Med / Peds
Deborah Blenyer	ECU Med/Peds
	NC SA
	NCALHD
Johnny Tillett	Tillett Lobbying Group
	NP Assoc

Senate Health Care Committee
Wednesday, March 23, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 40	**Falsify Info/Adult Care Home License/Penalty.**	**Senator Swindell IV**
SB 506	**Cancer Registry.**	**Senator Purcell**
SB 572	**License Assisted Living Facil./Elderly.**	**Senator Swindell IV**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, March 23, 2005

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

FAVORABLE

S.B. **506** Cancer Registry.
Sequential Referral: None
Recommended Referral: None

S.B. **572** License Assisted Living Facil./Elderly.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, March 23, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, March 23, 2005, in Room 544 of the Legislative Office Building, with fifteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator William R. Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senate Bill 40, ***Falsify Info/Adult Care Home License/Penalty.***, was pulled from the agenda.

Senator Bingham introduced Senator Swindell to present Senate Bill 572, ***License Assisted Living Facil./Elderly.*** He said this subject was discussed in the Commission on Aging meetings, which he Co-Chairs, and was discussed throughout the communities responsible for the care of our senior citizens, elderly, and disabled. This legislations sets up a separate licensing category for adult care homes that serve only elderly persons, allowing people to find a facility without a mixed population. Senator Dannley moved for a favorable report. Senator Jacumin asked if a husband and wife both having an elderly parent they are caring for would be affected. Jerry Copper, Assisted Living Association, stated this bill would not have any impact on family members caring for each other; it only affects licensed residential care facilities. The bill passed.

Senator Purcell was recognized to present, Senate Bill 506, ***Cancer Registry***, and to introduce a friend of his. He introduced the Nurse of the Day, Sandra Tucker and the Doctor of the Day, Dr. Brian Parks, a surgeon from his community. Also he recognized some Student Nurse Anesthetists from Wake Forest. Senator Purcell asked Karen Knight, with the NC Central Cancer Registry, to explain the bill. The NC Central Cancer Registry are authorized through legislation to collect all cases of cancer that are diagnosed or treated in NC with the purpose of following those cases and cancer trends in the state. They may use the data to target the public health resources in terms of screening treatment. The public also uses the data. They get a lot of calls from the public inquiring about cancer in their neighborhood. This particular proposal adds to what is currently required to be reported. It will add any benign brain or central nervous system tumors to the cancers they currently collect. There is a federal law that already requires this and is funded through the Centers for Disease Control and Preventions (CDC). This bill is to bring NC in compliance with the federal law. There is a potential for losing some money if this is not done. They were funded six hundred fifty thousand dollars this past year through CDC and through their National Program of Cancer Registries. Senator Forrester stated with malignant cancers already having to be reported, when this bill is adopted, it will then be all brain and central nervous system tumors. Ms. Knight replied that was correct. Senator Hoyle asked if the agency had any problem with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Ms. Knight stated that

they are a public health entity and they are exempt from HIPAA. Senator Lucas asked who was privileged to see the registry. Ms. Knight responded that in the state law it says that the data can be released if it is for the public health's good. Senator Berger asked if data is collected on patients who have been exposed to asbestos. Ms. Knight responded that the asbestos data is not in their database. Senator Kinnaird asked about a small town, Bynum in Orange County that had a lot of cancer patients and wanted to know if when they find a cluster, do they send a team to investigate. Ms. Knight responded that the first thing they do is to educate them then they look on a map and analyze the data to check out the exposures. In most cases the exposures, then the disease and the latency between the two are a really long time. So by the time cancer shows up it could be twenty years later. Senator Malone asked if code numbers instead of name lists are in the registry. Ms. Knight responded that they do have the individual names so they can follow them in terms of death and match their data with death certificates. Most of the data released is done in aggregate form. Senator Forrester asked if someone got into their computer and obtained information would they have to notify those individuals that their identity had been compromised. Ms. Knight stated they have never had to deal with that situation stating they have a highly secure system. Senator Lucas asked where they are located. Ms. Knight replied two blocks away in the Cotton Building on the corner of Lane and Dawson Street. Senator Bingham asked about the Federal and State Dollar losses if they do not do this. Senator Purcell said the state puts in eight hundred thousand dollars and the federal match is six hundred thousand dollars. So NC would be losing the six hundred thousand dollars. Senator Hartsell made a motion for a favorable report. The bill passed.

The meeting adjourned at 11:30 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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 40*

Short Title:	Falsify Info/Adult Care Home License/Penalty.	(Public)
Sponsors:	Senators Swindell, Dannelly, Allran; Albertson, Apodaca, Berger of Franklin, Bingham, Boseman, Dalton, Garwood, Hoyle, Jenkins, Lucas, Malone, Purcell, Rand, Snow, Stevens, and Tillman.	
Referred to:	Health Care.	

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO IMPOSE A CIVIL PENALTY ON ANY ADULT CARE HOME LICENSURE APPLICANT WHO FALSIFIES OR OMITS MATERIAL INFORMATION ON THE APPLICATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-34 is amended by adding a new subsection to read:

"(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits material information on an application. The amount of the penalty shall be as is prescribed for a Type A violation."

SECTION 2. This act becomes effective December 1, 2005, and applies to violations committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 572

Short Title:	License Assisted Living Facil./Elderly.	(Public)
Sponsors:	Senators Swindell; Jenkins and Malone.	
Referred to:	Health Care.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO CREATE A LICENSURE CATEGORY FOR ASSISTED LIVING COMMUNITIES THAT SERVE ONLY ELDERLY ADULTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(a)(1d) 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:

...

(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,~~ October 1, 2005, there are two types of assisted living residences: adult care homes and ~~group homes for developmentally disabled adults.~~adult care homes that serve only elderly persons. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

Effective July 1, 1996, there is a third type, multiunit assisted housing with services."

SECTION 2. The Medical Care Commission shall adopt rules to implement this act.

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

SENATE BILL 572:
License Assisted Living Facil./Elderly

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Swindell
Date:	March 23, 2005	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 572 would establish a separate licensure category for adult care homes that serve only elderly adults, effective October 1, 2005. The act would become effective when it becomes law.***

CURRENT LAW: An adult care home is an assisted living residence that makes available, at a minimum, one meal a day; housekeeping services, and personal care services. Adult care homes are licensed by the Division of Facility Services, Department of Health and Human Services and operate under rules adopted by the Medical Care Commission. There are over 1,400 adult care homes in the State.

BILL ANALYSIS: Senate Bill 572 would delete the category of adult care homes of "homes for developmentally disabled adults" (as these homes are now licensed under Chapter 122C) and create a new category named "adult care homes that serve only elderly persons". This would permit homes to be licensed to serve only this category of client. For purposes of this category "elderly person" would mean:

- Any person age 55 or older who requires assistance with activities of daily living, housing, and services; or
- Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services.

The Medical Care Commission would adopt rules to implement this change.

BACKGROUND: Prompted by concerns raised by advocates and the public, the North Carolina Study Commission on Aging has studied the issue of the adequacy of rules and licensure requirements for adult care homes that care for mentally ill residents and mixed populations in adult care homes. According to the Division of Facility Services, the following rules relate to the care for mentally ill residents in adult care homes:

Admission of Residents (10A NCAC 13G .0701)
- Prohibits admission of persons for treatment of mental illness
- Prohibits admission of persons who pose direct threat to the health or safety of others

Medical Examination (10A NCAC 13G .0702)
- Have to arrange for examination by physician of any new resident who was an inpatient of a psychiatric facility within the 12 months prior to admission

Personal Care Training and Competence (10A NCAC 13G .0502
- 80 hour training
- 25 hour training (Family Care Homes only)

Training includes 5 hours training on interventions to reduce behavioral problems

Special Care Units* for Mental Health Disorders (10A NCAC 13F .1401)

- Provides for a closed unit for up to 12 beds for persons with a mental health disability
- Requires additional training for staff
- Requires assessment and care planning review and case management by area mental health program

*Currently none licensed in N.C.

In its recommendations to the 2004 General Assembly, the Commission recommended that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities. This recommendation was enacted in the 2004 budget bill (S.L. 2004-124, Sec. 10.2(a)). The report of this study is due to the NC Study Commission on Aging on October 1, 2005.

S572-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 506

Short Title:	Cancer Registry.	(Public)
Sponsors:	Senators Purcell; Dorsett and Malone.	
Referred to:	Health Care.	

March 15, 2005

A BILL TO BE ENTITLED

AN ACT TO BRING NORTH CAROLINA LAW INTO COMPLIANCE WITH PUBLIC LAW 107-260, THE BENIGN BRAIN TUMOR CANCER REGISTRIES AMENDMENT.

The General Assembly of North Carolina enacts:

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

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

(a) All health care facilities and health care providers that detect, diagnose, or treat cancer or benign brain or central nervous system tumors shall report to the central cancer registry each diagnosis of cancer or benign brain or central nervous system tumors in any person who is screened, diagnosed, or treated by the facility or provider. The reports shall be made within six months of diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report.

(b) If a health care facility or health care provider fails to report as required under this section, then the central cancer registry may conduct a site visit to the facility or provider or be provided access to the information from the facility or provider and report it in the appropriate format. The Commission may adopt rules requiring that the facility or provider reimburse the registry for its cost to access and report the information in an amount not to exceed one hundred dollars ($100.00) per case. Thirty days after the expiration of the six-month period for reporting under subsection (a) of this section, the registry shall send notice to each facility and provider that has not submitted a report as of that date that failure to file a report within 30 days shall result in collection of the data by the registry and liability for reimbursement imposed under this section. Failure to receive or send the notice required under this section shall not be construed as a waiver of the reporting requirement. For good cause, the central cancer registry may grant an additional 30 days for reporting.

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

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

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

SECTION 2. This act becomes effective January 1, 2006.

SENATE BILL 506: Cancer Registry.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Purcell
Date:	March 22, 2005	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 506 would bring North Carolina law into compliance with Public Law 107-260, the Benign Brain Tumor Cancer Registries Amendment Act, by adding benign brain tumors and central nervous system tumors to the diagnoses that health care facilities and providers must report to the North Carolina Central Cancer Registry (NCCCR).***

CURRENT LAW: General Statute 130A-208 establishes a central cancer registry within the Department of Health and Human Services and sets forth the duties and tasks assigned to the registry – "...compile, tabulate and preserve statistical, clinical and other reports and records relating to the incidence, treatment and cure of cancer received..."[1]. General Statute 130A-209 sets forth the reporting procedure and timeline to be followed by treating health care facilities or providers[2]. The statute then sets forth the procedure to be followed in the event that data is not reported to the central registry as required – site visits and reimbursement of costs incurred by the registry conducting the site visit to collect the unreported data[3].

BILL ANALYSIS: Senate Bill 506 would add two categories of tumors, benign brain tumors and central nervous system tumors, to the diagnoses about which the NCCCR is directed to collect information and that health care facilities and health care providers are required to report to the NCCCR. This bill would bring North Carolina into compliance with the Benign Brain Tumor Cancer Registries Amendment Act[4], which added those types of tumors to the more general term of 'cancer' included in the section of the United States Code creating the National Program of Cancer Registries[5].

The overall effect of this bill would be twofold:

1) It would avoid the possibility of jeopardizing future grant funding due to a lack of consistency between state and federal language; and

2) it would aid the NCCCR in its efforts to collect complete information from health care facilities and health care providers.

BACKGROUND: The NCCCR is a program of the North Carolina State Center for Health Statistics, which is within the North Carolina Department of Health and Human Services. The NCCCR collects, processes, and analyzes data on all cancer cases diagnosed among North Carolina residents. The NCCCR receives its funding on an annual basis from the state and the federal government though a matching grant funding arrangement. The most recent federal grant monies provided to the NCCCR totaled approximately $700,000.

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[1] G.S. 130A-208.
[2] G.S. 130A-209(a).
[3] G.S. 130A-209(b).
[4] Public Law 170-260.
[5] 42 U.S.Code 280e "National Program of Cancer Registries".

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **March 23, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Johnny Tillett	Lobbying - Gray
Mark Mosn	WFUBMC - Nurse Anesthesia Program
Terri Wallace	Wake Forest University Baptist Medical Center Nurse Anesthesia Program
Alex Johnson	WFUBMC - Nurse Anesthesia Program
Thomas Mueller	WFUBMC - Nurse Anesthesia Program
Stella McKenny RN, BC, CCRN, FCCST, BSN, MBA, MN	NC DHHS
Sandra Drucker - Student	Nurse of the day
Brian Parkes MD.	Dr. of the Day
Amanda Lassiter	Wake Forest Univ. Baptist Medical Center Nurse Anesthesia Program
Andra Haverly	Wake Forest University Baptist Medical Center - Nurse Anesthesia Program
Shane Harrison	Wake Forest University Nurse anesthesia program

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **March 23, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Bone	Bone & Assoc
Gregg Jo Horne	NCMS
Angela Wilburn	Wake Forest Univ. Baptist Medical Center
Cheryl Straub, SRNA	Wake Forest Univ. Baptist Medical Center
Julie Reynolds, SRNA	Wake Forest Univ. Baptist Medical Ctr
Joanne Stevens	nursing
HUGH TILSON	NCHA
Amy Wada SRNA	Wake Forest University Baptist Medical Center
Karen A. Hall, SRNA	Wake Forest University Baptist Medical Center
Virginia M. Garris	Wake Forest University Baptist Medical Center
	JH, AL, PA
Lon Wilson	NCANCT

AGENDA

SENATE HEALTH CARE COMMITTEE
March 30, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered:**

- **SB 482, Indoor Arena Smoking Regulations**
- **SB 665, County Medicaid Billing Systems**
- **SB 765, Increase Area MH/DD/SAS Bd Membership**
- **SB 118, Medicaid Case Management/Prescription Drugs**

III. **Other Business**

IV. **Adjournment**

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, March 30, 2005

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

FAVORABLE

S.B.	**118**	Medicaid Case Management/Prescription Drugs.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**482**	Indoor Arena Smoking Regulations.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**765**	Increase Area MH/DD/SAS Bd Membership.	
		Sequential Referral:	None
		Recommended Referral:	None

TOTAL REPORTED: 3

Committee Clerk Comments:

SENATE HEALTH AND HUMAN RESOURCES COMMITTEE
Wednesday, March 30, 2005
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 30, 2005, in Room 544 of the Legislative Office Building, with ten members present. Senator William R. Purcell, Co-Chair, presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. Senator Purcell welcomed the group of Certified Registered Nurse Anesthetists and the group of Anesthesiologists in attendance.

Senator Purcell said that SB 665, *County Medicaid Billing System*, would not be heard at this meeting, at the request of the bill sponsor. He turned the meeting over to Senator Dorsett in order that he could present his bill, SB 765, *Increase Area MH/DD/SAS Bd Membership*. He explained that the Sandhills Center for Mental Health Development covers an eight-county area, with a population of over 500,000 people. There are 25 board members at present, and in order to represent this area fairly and adequately, the request was made to increase board membership to 30. Senator Allran asked if there is any opposition to this bill, and Senator Purcell answered that no one had made any objections that he knows of. Senator Allran moved for a favorable report, and the bill passed.

Senator Purcell introduced SB 118, *Medicaid Case Management/Prescription Drugs*, and said that this bill came about at the recommendation of the Blue Ribbon Commission on Medicaid Reform. As a result of the study it was discovered that many people, especially the elderly are taking a number of drugs, sometimes by going from doctor to doctor, with a possible result that the drugs may not be compatible. This bill is a recommendation that the Division of Medical Assistance, DHHS, develop a case management program such that the number of these drugs can be managed. Senator Hoyle asked if this program would be applied to people in institutions, would it be all Medicaid patients, or just a certain class. Senator Purcell responded that it would apply to all Medicaid patients. Senator Allran expressed concern as to how this plan would be developed. Senator Goodall moved for a favorable report, and the bill passed.

Senator Dorsett presented her bill, SB 482, *Indoor Arena Smoking Regulations,* to the committee. She introduced Ms. Blair Carr, an attorney from Greensboro. Senator Dorsett said that this bill would affect the Greensboro and Charlotte Coliseums, in order that they can have more restrictive regulations than at present. Senator Allran moved for a favorable report and the bill passed.

The meeting adjourned at 10: 22 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 2005

S 1

SENATE BILL 118

Short Title:	Medicaid Case Management/Prescription Drugs.	(Public)
Sponsors:	Senators Purcell, Dannelly, Hartsell; Albertson, Allran, Atwater, Bingham, Boseman, Dorsett, Forrester, Garwood, Graham, Holloman, Jenkins, Kerr, Kinnaird, Lucas, Malone, Rand, Snow, Soles, and Swindell.	
Referred to:	Health Care.	

February 14, 2005

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO DEVELOP A CASE MANAGEMENT PROGRAM FOR RECIPIENTS HAVING A LARGE NUMBER OF PRESCRIPTIONS, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall develop a case management program to provide case management services to Medicaid recipients that have a large number of prescriptions. The Department of Health and Human Services shall report on the development of the program not later than January 1, 2006, to 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.

SECTION 2. This act becomes effective July 1, 2005.

SENATE BILL 118:
Medicaid Case Management/Prescription Drugs

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Purcell
Date:	March 30, 2005	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 118 is a recommendation of the Blue Ribbon Commission on Medicaid Reform. It would direct the Department of Health and Human Services (DHHS) to provide case management services to Medicaid recipients that have a large number of prescriptions. The act would become effective July 1, 2005.***

CURRENT LAW: Under the Medicaid program, recipients are allowed up to six prescriptions per month, including refills. According to the Fiscal Research Division, Medicaid expenditures for drugs were $1.47 billion in FY 2004. In FY 2003, drugs comprised 19.6% of expenditures for Medicaid services.

The State has undertaken measures to control Medicaid prescription drug costs. Certain drugs are subject to prior authorization,[1] and the use of generic drugs is encouraged.

BILL ANALYSIS: The bill would direct the Division of Medical Assistance in DHHS to develop a case management program to provide case management services to Medicaid recipients that have a large number of prescriptions. DHHS would report on the development of the program not later than January 1, 2006 to the Senate and House Appropriations subcommittees on Health and Human Services and the Fiscal Research Division.

BACKGROUND: According to the report of the Blue Ribbon Commission on Medicaid Reform, Dr. Marshall R. Thomas, Vice-President Medical Services and Medical Director for Colorado Access spoke at a NCSL meeting in December about Colorado's case management program. Colorado's program targeted mentally ill Medicaid recipients that were large users of prescription drugs for their mental illnesses and other health issues. By completing a comprehensive review of these recipients' medications, Colorado Access was able to eliminate duplicative and medically unnecessary prescription drugs, and save money for the Colorado Medicaid Program.

S118-SMSW-001

[1] Effective 9/7/2004, the drugs on the prior authorization list are: Procrit/Epogen, Neupogen, OxyContin, Growth Hormones, Provigil, Celebrex, Bextra, Botox, Myobloc, and Aranesp.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 482*

Short Title:	Indoor Arena Smoking Regulations.	(Public)
Sponsors:	Senators Dorsett and Hagan.	
Referred to:	Health Care.	

March 10, 2005

A BILL TO BE ENTITLED

AN ACT TO EXEMPT LARGE INDOOR ARENAS WITH SEATING CAPACITIES GREATER THAN TWENTY-THREE THOUSAND FROM SMOKING REGULATIONS PROVIDED FOR IN ARTICLE 64 OF CHAPTER 143 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-599 reads as rewritten:

"**§ 143-599. Exemptions.**

All of the following facilities shall be exempt from the provisions of this Article:

(1) Any primary or secondary school or child care center, except for a teacher's lounge.

(2) An enclosed elevator.

(3) Public school bus.

(4) Hospital, nursing home, rest home, and State facility operated under the authority of G.S. 122C-181.

(5) Local health department.

(6) Any nonprofit organization or corporation whose primary purpose is to discourage the use of tobacco products by the general public.

(7) Tobacco manufacturing, processing, and administrative facilities.

(8) Indoor arenas with a seating capacity greater than 23,000."

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

SENATE BILL 482:
Indoor Arena Smoking Regulations

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senators Dorsett and Hagan
Date:	March 25, 2005	**Summary by:**	Shawn Parker
Version:	First Edition		Committee Staff

SUMMARY: ***Senate Bill 482 would exempt the Greensboro Coliseum Complex and the Charlotte Coliseum from current laws governing smoking restrictions. This act would be effective when it becomes law.***

CURRENT LAW: Article 64 of the General Statutes addresses the needs and concerns of both smokers and nonsmokers in public places by providing for designated smoking and nonsmoking areas[1]. A list of buildings owned, leased or occupied by state government which may be designated as nonsmoking areas is set forth, including: museums, libraries, UNC health services facilities. Nonsmoking areas must be visibly posted as such, and requirements for separate ventilation systems and physical barriers between nonsmoking and adjacent smoking areas are provided for in the statute[2].

Violation by continuing to smoke in a nonsmoking area after having been given notice to stop smoking is an infraction punishable by a fine of not more than $25.00[3]. Local ordinances, laws or rules passed on or after October 15, 1993 regulating smoking may not contain restrictions exceeding those of Article 64 and may only address smoking in specifically identified types of facilities[4]. An itemized list of facilities is specifically exempted from regulation by the provisions of Article 64 and includes the following: any primary or secondary school, child care center (teacher's lounge excepted), enclosed elevators, public school buses, hospitals, nursing homes, rest homes, local health departments, organizations intended to discourage tobacco use, and tobacco manufacturing, processing and administrative facilities[5].

BILL ANALYSIS: Senate Bill 482 would amend G.S. 143-599 by adding indoor arenas with a seating capacity greater than 23,000 to the list of facilities exempt from the provisions of Article 64, permitting officials for the Greensboro Coliseum Complex (23,500 capacity) and the Charlotte Coliseum (24,000 capacity) to prohibit smoking in the facility.

BACKGROUND: The City of Charlotte intends to transfer ownership of the Charlotte Coliseum by October of 2005.

S482-SMSQ-001

[1] G.S. 143-595.
[2] G.S. 143-597(b) & (c).
[3] G.S. 143-598.
[4] G.S. 143-601(b).
[5] G.S. 143-599.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 665*

Short Title:	County Medicaid Billing Systems.	(Public)
Sponsors:	Senators Hartsell; and Holloman.	
Referred to:	Health Care.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE PUBLIC HEALTH AUTHORITIES TO CONTRACT DIRECTLY WITH PRIVATE VENDORS TO OPERATE THE COUNTY BILLING SYSTEM FOR MEDICAID CLAIMS.

Whereas, the county share of the nonfederal share of Medicaid costs has a significant impact on county resources and cash flow; and

Whereas, more timely reimbursement of county Medicaid claims would improve county cash flow; and

Whereas, the current process for Medicaid billing is more complicated than necessary; and

Whereas, contracting with a private vendor to interface directly with the State Medicaid billing system would make the billing process for county Medicaid claims much simpler than it now is; and

Whereas, county public health authorities would benefit from private vendor-operated Medicaid billing by enabling the authorities to optimize revenue through efficiencies that are currently not in place through the State billing system; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 1B of Article 2 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-45.13. Authority to contract directly with private providers to operate billing system for county Medicaid claims.**

A public health authority board may contract directly with private vendors to operate the authority's Medicaid billing system as an alternative to the State-operated health services information system. The contract may provide for the private vendor to bill directly the State Medicaid billing system (MMIS), thereby bypassing the State health services information system (HSIS). The public health authority shall issue a "request for proposal" to solicit private vendor bids for contracts authorized under this section."

SECTION 2. This act is effective when it becomes law and applies to county Medicaid claims arising on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 765

Short Title:	Increase Area MH/DD/SAS Bd Membership.	(Public)
Sponsors:	Senators Purcell; Albertson, Bingham, Dannelly, Holloman, Lucas, and Malone.	
Referred to:	Health Care.	

March 22, 2005

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE NUMBER OF BOARD MEMBERS FOR CERTAIN MULTICOUNTY AREA PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-118.1(a) reads as rewritten:

"(a) An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties and serving a catchment area with a population of more than 500,000 may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include an individual with financial expertise or a county finance officer, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term."

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

SENATE BILL 765:
Increase Area MH/DD/SAS Bd Membership.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Purcell
Date:	March 30, 2005	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 765 would increase the maximum number of board members that could serve on certain area boards. Multicounty area authorities consisting of eight or more counties and serving catchment areas with populations of more than 500,000 would be allowed to have up to 30 board members. This act would be effective when it became law.***

CURRENT LAW: Within the public system of mental health, developmental disabilities, and substance abuse services, there are area, county, and State facilities. An area authority or county program is the locus of coordination among public mental health, developmental disabilities, and substance abuse services for clients of its catchment area[1]. The governing unit of the area authority is the area board. All powers, duties, functions, rights, privileges, or immunities conferred on the area authority may be exercised by the area board[2]. Area boards may have no fewer than 11 and no more than 25 members[3].

BILL ANALYSIS: Senate Bill 765 would increase the maximum number of area board members who may serve on the board for an area authority consisting of eight or more counties and serving a catchment area with a population of more than 500,000. The minimum would remain 11, while the maximum would increase from 25 to 30 board members.

BACKGROUND: At present, no area authorities currently meet the population size and county number criteria set forth by this bill. Two area authorities may soon be affected by the bill, however – the Western Highlands Network and the Sandhills Center for mental health, developmental disabilities, and substance abuse services. Western Highlands operates in Buncombe, Madison, Mitchell, Yancey, Henderson, Transylvania, Rutherford and Polk Counties and serves a catchment area of just under 500,000. It may fall within the effect of this bill as its population grows.

The Sandhills Center will meet the criteria of this bill when it adds two additional counties (Lee and Harnett) this coming July. At present the Sandhills Center provides services to the citizens in the following six counties in south-central North Carolina: Anson, Hoke, Montgomery, Moore, Randolph and Richmond.

S765-SMSS-001

[1] G.S. 122C-101.
[2] G.S. 122C-117(b).
[3] G.S. 122C-118.1(a).

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

MARCH 30, 2005 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tammy Brunner	Winning Strategies
Simon W. Chao, MD	North Carolina Society of Anesthesiology — WFUBMC DEPT. ANESTHESIA
Debra Toone, MD	North Carolina Society of Anesthesiology / Baptist Hospital
Ashley Tonidandel, MD	North Carolina Society of Anesthesiology WFUBMC - (Mocksville)
Alan Koontz, M.D.	North Carolina Society of Anesthesiologists Winston-Salem, N.C.
Pamela C Nagle MD	NC Society of Anesthesiology NC Baptist Hospital - Winston Salem, NC
Gerald A. Maccioli, MD	NC Society of Anesthesiologists
W. Fred Obrecht M.D	NC Society of Anesthesiologists Columbus Regional Healthcare System
A. Bath, MD	NC Society of Anesthesiologists
Dana Simpson	NC Society of Anesthesiologists
Richard Pollard MDD	NC Society of Anesthesiologists Belmont NC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 30, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wm. Gavin Elliott, MD, MMM	North Carolina Society of Anesthesiologists
JOHN BUTTERWORTH, MD	NC SOCIETY OF ANESTHESIOLOGISTS
[signature]	[illegible]
Scott K. Garrison, MD	NCSA
Larry C. Field, MD	NCSA
Heather Frederick MD	NCSA
Anne T. Lunney, MD	NCSA
AMY ISENBERG, MD	NC Society of Anesthesiologists
[signature]	[signature]
Delores Manning, CRNA	NCANA (N.C. Assoc. of Nurse Anesthetists)
Kandace Thomas, CRNA	NCANA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 30, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marcia Cuine, SRNA	Wake Forest University School of Anesthesia for Nurses
Cliff Gonzales, SRNA	
April Carter, SRNA	
Dan Cadicle SRNA	
Shida Forcadela SRNA	
Suzanne Gregory SRNA	
Andrea Fan SRNA	
Brandi Morgan SRNA	

Senate Health Care Committee
Wednesday, April 6, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 711	NC Dental Board/Exams & Real Property.	Senator Swindell IV
SB 768	NC Health Choice/Control Utilization & Cost.	Senator Purcell
SB 1128	Medicaid: No Preauth. for Certain Drugs.	Senator Dalton

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, April 07, 2005

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

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

S.B. **711** NC Dental Board/Exams & Real Property.

Draft Number:	PCS55206
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, April 6, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 6, 2005, in Room 544 of the Legislative Office Building, with thirteen members present. Senator Stan Bingham presided. Senator Bingham and Senator William R. Purcell, Co-Chairs, welcomed the committee member present and introduced the pages.

Senate Bill 768, ***NC Health Choice/Control Utilizations & Cost***, and Senate Bill 1128, ***Medicaid: No Preauth. for Certain Drugs***, were pulled from the agenda.

Senator Bingham called upon Senator Swindell to explain Senate Bill 711, ***NC Dental Board/Exams & Real Property***. He said the legislation deals with the NC Dental Board and how they can purchase real estate for their offices and the examinations of dentists to be licensed in NC. It puts the authority in The Dental Board when it comes to exams. There is now a work in progress throughout the US involving forty-four states as far as having a comprehensive clinical dental examination that would be accepted as a National Examination for dentist. Without this bill we will just have our standard examination. The second part of the bill deals with the right to do real estate transactions. There are other boards with that right including, the NC Medical Board, the Land Surveyors and the Real Estate Board. If a dentist is looking for a sight they go to purchasing contracts and look at all the properties. After making a decision, they go before the Council of State for approval. Senator Dorsett inquired about the National Exam asking if there was any legal part unique to NC. William Potter, NC Dental Society, stated the current law in NC requires an examination to determine clinical competence but the law in addition to that requires everyone licensed as a Dentist to pass two additional tests. One being the Jurisprudence Test which makes sure they understand the unique nature of some of NC laws. The second test is an Infection Control Test. Senator Jacumin inquired about the real estate part of the bill as to whether the property becomes tax exempt at the point of acquisition. Mr. Potter responded it is not treated as tax exempt, it would not become state owned property; it will be treated as a quasi-public corporate entity. Senator Dannely moved for a favorable report. There was a Proposed Committee Substitute and Senator Dannley moved to hear the PCS. Dr. Benjamin Brown, President of NC State Board of Dental Examiners, made the statement that this national exam would be equal or be better than what they have. The bill passed.

The meeting adjourned at 11:18 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 711

Short Title:	NC Dental Board/Exams & Real Property.	(Public)
Sponsors:	Senators Swindell, Stevens; Albertson, Apodaca, Bingham, Forrester, Garwood, Holloman, Hoyle, Jenkins, Thomas, Tillman, and Weinstein.	
Referred to:	Health Care.	

March 21, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS TO ACCEPT, IN ADDITION TO EXAMINATIONS CONDUCTED BY THE BOARD, THE RESULTS OF OTHER BOARD-APPROVED REGIONAL OR NATIONAL INDEPENDENT THIRD-PARTY CLINICAL EXAMINATIONS OF APPLICANTS SEEKING A LICENSE TO PRACTICE DENTISTRY; AND AUTHORIZING THE BOARD TO ACQUIRE REAL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-30(a) reads as rewritten:

"(a) The North Carolina State Board of Dental Examiners shall grant licenses to practice dentistry to such applicants who are graduates of a reputable dental institution, who, in the opinion of a majority of the Board, shall undergo a satisfactory examination of proficiency in the knowledge and practice of dentistry, subject, however, to the further provisions of this section and of the provisions of this Article.

The applicant for a license to practice dentistry shall be of good moral character, at least 18 years of age at the time the application ~~for examination~~ is filed. The application for a dental license shall be made to the ~~said~~ Board in writing and shall be accompanied by evidence satisfactory to ~~said~~ the Board that the applicant is a person of good moral character, has an academic education, the standard of which shall be determined by the ~~said~~ Board; that ~~he~~ the applicant is a graduate of and has a diploma from a reputable dental college or the dental department of a reputable university or college recognized, accredited and approved as such by the ~~said Board.~~ Board; and that the applicant has passed a clinical licensing examination, the standard of which shall be determined by the Board.

The North Carolina State Board of Dental Examiners is authorized to conduct both written or oral and clinical examinations or to accept the results of other Board-approved regional or national independent third-party clinical examinations that

include procedures performed on human subjects as part of the assessment of restorative clinical competencies and that are determined by the Board to be of such character as to thoroughly test the qualifications of the applicant, and may refuse to grant a license to any person who, in its discretion, is found deficient in ~~said examination, or~~the examination. The Board may refuse to grant a license to any person guilty of cheating, deception or fraud during ~~such~~ the examination, or whose examination discloses to the satisfaction of the Board, a deficiency in academic or clinical education. The Board may employ ~~such~~ all dentists found qualified therefor by the Board, in examining applicants for licenses as it deems appropriate.

The North Carolina State Board of Dental Examiners may refuse to grant a license to any person guilty of a crime involving moral turpitude, or gross immorality, or to any person addicted to the use of alcoholic liquors or narcotic drugs to such an extent as, in the opinion of the Board, renders the applicant unfit to practice dentistry.

Any license obtained through fraud or by any false representation shall be void ab initio and of no effect."

SECTION 2. G.S. 90-39(1) reads as rewritten:

"**§ 90-39. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules not exceeding the following:

(1) Each application for general dentistry ~~examination~~license $1,200

...."

SECTION 3. G.S. 90-28 reads as rewritten:

"**§ 90-28. Bylaws and ~~regulations.~~regulations; acquisition of property.**

(a) The North Carolina State Board of Dental Examiners shall have the power to make necessary bylaws and regulations, not inconsistent with the provisions of this Article, regarding any matter referred to in this Article and for the purpose of facilitating the transaction of business by the ~~said~~ Board.

(b) The Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 711
PROPOSED COMMITTEE SUBSTITUTE S711-CSSS-2 [v.1]

4/5/2005 4:38:19 PM

Short Title: NC Dental Board/Exams & Real Property. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS TO ACCEPT, IN ADDITION TO EXAMINATIONS CONDUCTED BY THE BOARD, THE RESULTS OF OTHER BOARD-APPROVED REGIONAL OR NATIONAL INDEPENDENT THIRD-PARTY CLINICAL EXAMINATIONS OF APPLICANTS SEEKING A LICENSE TO PRACTICE DENTISTRY; AND AUTHORIZING THE BOARD TO ACQUIRE REAL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-30(a) reads as rewritten:

"(a) The North Carolina State Board of Dental Examiners shall grant licenses to practice dentistry to such applicants who are graduates of a reputable dental institution, who, in the opinion of a majority of the Board, shall undergo a satisfactory examination of proficiency in the knowledge and practice of dentistry, subject, however, to the further provisions of this section and of the provisions of this Article.

The applicant for a license to practice dentistry shall be of good moral character, at least 18 years of age at the time the application ~~for examination~~ is filed. The application for a dental license shall be made to the ~~said~~ Board in writing and shall be accompanied by evidence satisfactory to ~~said~~ the Board that the applicant is a person of good moral character, has an academic education, the standard of which shall be determined by the ~~said~~ Board; that ~~he~~ the applicant is a graduate of and has a diploma from a reputable dental college or the dental department of a reputable university or college recognized, accredited and approved as such by the ~~said Board.~~Board; and that the applicant has passed a clinical licensing examination, the standard of which shall be determined by the Board.

The North Carolina State Board of Dental Examiners is authorized to conduct both written or oral and clinical examinations or to accept the results of other Board-approved regional or national independent third-party clinical examinations that

shall include procedures performed on human subjects as part of the assessment of restorative clinical competencies and that are determined by the Board to be of such character as to thoroughly test the qualifications of the applicant, and may refuse to grant a license to any person who, in its discretion, is found deficient in ~~said examination, or~~the examination. The Board may refuse to grant a license to any person guilty of cheating, deception or fraud during ~~such~~ the examination, or whose examination discloses to the satisfaction of the Board, a deficiency in academic or clinical education. The Board may employ such dentists found qualified therefor by the Board, in examining applicants for licenses as it deems appropriate.

The North Carolina State Board of Dental Examiners may refuse to grant a license to any person guilty of a crime involving moral turpitude, or gross immorality, or to any person addicted to the use of alcoholic liquors or narcotic drugs to such an extent as, in the opinion of the Board, renders the applicant unfit to practice dentistry.

Any license obtained through fraud or by any false representation shall be void ab initio and of no effect."

SECTION 2. G.S. 90-39(1) reads as rewritten:

"**§ 90-39. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules not exceeding the following:

(1) Each application for general dentistry ~~examination~~license ..... $1,200 ...."

SECTION 3. G.S. 90-28 reads as rewritten:

"**§ 90-28. Bylaws and ~~regulations.~~regulations; acquisition of property.**

(a) The North Carolina State Board of Dental Examiners shall have the power to make necessary bylaws and regulations, not inconsistent with the provisions of this Article, regarding any matter referred to in this Article and for the purpose of facilitating the transaction of business by the ~~said~~ Board.

(b) The Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board."

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

SENATE BILL 711:
NC Dental Board/Exams & Real Property.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Swindell
Date:	April 6, 2005	**Summary by:**	Ben Popkin
Version:	S711-CSSS-2[v.1]		Committee Counsel

SUMMARY: ***Senate Bill 711 would authorize the North Carolina State Board of Dental Examiners to accept the results of Board-approved regional or national independent third-party clinical examinations of applicants seeking a license to practice dentistry. The bill would also authorize the North Carolina State Board of Dental Examiners to acquire real property. The Proposed Committee Substitute would make technical modifications to the language of the bill. The act would be effective when it becomes law.***

CURRENT LAW: Article 2 (Dentistry) of Chapter 90 (Medicine, Allied Occupations) of the North Carolina General Statutes addresses the practice of dentistry in North Carolina. The North Carolina State Board of Dental Examiners is set forth as "the agency of the State for the regulation of the practice of dentistry in this State"[1]. The North Carolina State Board of Dental Examiners grants licenses to practice dentistry to applicants who meet the following criteria[2]:

- Are graduates of a reputable dental institution;
- Undergo a satisfactory examination of proficiency in the knowledge and practice of dentistry;
- Are of good moral character;
- Are at least 18 years of age; and
- Have not been convicted of a crime involving moral turpitude or gross immorality; or be addicted to alcohol or narcotic drugs.

The North Carolina State Board of Dental Examiners is authorized to conduct both written or oral and clinical examinations of such character as to thoroughly test the qualifications of the applicant[3].

BILL ANALYSIS: Senate Bill 711 would expand the examinations that the North Carolina State Board of Dental Examiners would consider as proof of the qualifications of an applicant to practice dentistry in the State. Regional or national independent third-party examinations that have been approved by the North Carolina State Board of Dental Examiners would be allowed as evidence of an applicant's proficiency in the knowledge and practice of dentistry.

The bill would also add a subsection to General Statute 90-28 (Bylaws and regulations) to authorize the North Carolina State Board of Dental Examiners to "acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation."

S711-SMSS-001

[1] G.S. 90-22(a).
[2] G.S. 90-30(a).
[3] G.S. 90-30(a).

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 768

Short Title:	NC Health Choice/Control Utilization & Cost.	(Public)
Sponsors:	Senators Purcell; Albertson, Atwater, Bingham, Boseman, Dannelly, Holloman, Kinnaird, Lucas, Malone, and Rand.	
Referred to:	Health Care.	

March 22, 2005

A BILL TO BE ENTITLED

AN ACT TO CONTROL UTILIZATION AND COST IN THE NC HEALTH CHOICE PROGRAM.

Whereas, it is in the interest of the State to control rising utilization and health care costs in the NC Health Choice Program; and

Whereas, Community Care of North Carolina maintains an existing primary care case management system that manages utilization and costs for the State's Medicaid population; and

Whereas, the Community Care of North Carolina network provides disease management and cost control methods that can help the State control utilization and costs in the NC Health Choice Program; and

Whereas, the use of Community Care of North Carolina network will be budget-neutral due to savings in the NC Health Choice Program resulting from increase case management; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-70.21 is amended by adding the following new subsection to read:

"(i) Case Management Services. – The Department shall utilize the Community Care of North Carolina network to provide primary care case management and disease management services to Program enrollees. The costs of providing the case management and disease management services shall be paid from Program funds. Payments made to primary care physicians and disease management networks in the Community Care of North Carolina network shall be equal to the level of compensation paid by the Medical Assistance Program for similar services."

SECTION 2. The Department of Health and Human Services shall report on the progress of NC Health Choice case management activities to 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 not later than October 1, 2005.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1128

Short Title:	Medicaid: No Preauth. for Certain Drugs.	(Public)
Sponsors:	Senator Dalton.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES SHALL NOT IMPOSE PRIOR AUTHORIZATION REQUIREMENTS ON CERTAIN PRESCRIPTION DRUGS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall not establish prior authorization requirements or other restrictions under the State Medical Assistance Program for FDA-approved medications indicated for the treatment of life-threatening respiratory conditions due to chronic obstructive pulmonary disease (COPD) or stroke. In developing a disease management program, the Department of Health and Human Services shall include initiatives that positively impact COPD and stroke-related health care costs.

SECTION 2. This act becomes effective July 1, 2005.

SENATE BILL 1128:
Medicaid:No Preauth. for Certain Drugs

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Dalton
Date:	April 5, 2005	**Summary by:**	Shawn Parker
Version:	1st edition		Committee Staff

SUMMARY: ***Senate Bill 1128 prohibits the Department of Health and Human Services from imposing prior authorization requirements on prescription drugs indicated for the treatment chronic obstructive pulmonary disease or stroke. The act is effective July 1, 2005.***

BILL ANALYSIS: The bill directs the Department of Health and Human Services (DHHS), as part of developing a disease management program, to include initiatives that positively impact the health care costs related to treating chronic obstructive pulmonary disease (COPD) and stroke. The bill prohibits the Division of Medical Assistance from establishing prior authorization requirements under the State Medical Assistance Program for FDA approved medications indicated for the treatment of life threatening respiratory conditions due to COPD or stroke.

Effective July 1, 2005

BACKGROUND: The National Institutes of Health defines Chronic Obstructive Pulmonary Disease (COPD) as a slowly progressive disease of the airways that is characterized by a gradual loss of lung function. The term COPD includes chronic bronchitis, chronic obstructive bronchitis, or emphysema, or combinations of these conditions. It represents the fourth leading cause of death in the U.S.

S1128-SMSQ-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 711
PROPOSED COMMITTEE SUBSTITUTE S711-PCS55206-SS-2

Short Title: NC Dental Board/Exams & Real Property. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS TO ACCEPT, IN ADDITION TO EXAMINATIONS CONDUCTED BY THE BOARD, THE RESULTS OF OTHER BOARD-APPROVED REGIONAL OR NATIONAL INDEPENDENT THIRD-PARTY CLINICAL EXAMINATIONS OF APPLICANTS SEEKING A LICENSE TO PRACTICE DENTISTRY; AND AUTHORIZING THE BOARD TO ACQUIRE REAL PROPERTY.

The General Assembly of North Carolina enacts:

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"(a) The North Carolina State Board of Dental Examiners shall grant licenses to practice dentistry to such applicants who are graduates of a reputable dental institution, who, in the opinion of a majority of the Board, shall undergo a satisfactory examination of proficiency in the knowledge and practice of dentistry, subject, however, to the further provisions of this section and of the provisions of this Article.

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

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 6, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MIKE MANN	NCCA
Tripp Melton	Intern
Virginia Garris	Wake Forest University Baptist Nurse Anesthesia School
Mark Moser	WFUBMC CRNA program
Amy Wada	WFUBMC Nurse Anesthesia Program
Shane Harrison	Wake Forest University Nurse Anesthesia student.
Hal Miller	NCACCT
Abby Emanuelson	NMSS
Vincent STEPHENS	Centers for Medicare + Medicaid Services (CMS)
Wayne Wilkins	State Budget Office
Debbie Barrow	State Budget Office

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 6, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nancy Heuler	DMA/DHHS
Tom D'Andrea	DMA/DHHS
Lacey Barnes	DMA/DHHS
Jeffrey Simms	DHHS
June Milby	DHHS-DMA-NCHC
Sig Hutchins	Self 520-B, Hwy Bldg. Inc. 27/20 64
Jeremy Cooper	NCACA
Evelyn Hawthorne	NCACA
	Allen Assoc

AGENDA

SENATE HEALTH CARE COMMITTEE
April 13, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

- **H.B. 45, Adult Protective Services TF/Collaborate** — **Rep. Nye**
- **S.B. 119, Ticket to Work/Medicaid Eligibility** — **Sen. Purcell**
- **H.B. 239, Smoking in Public Places/Local Health Dep** — **Rep. Wainwright**
- **S.B. 216, Coordination of Children's Services/Study** — **Sen. Nesbitt**
- **S.B. 489, Cosmetic Art Definitions/Exam Facilities** — **Sen. Cowell**
- **S.B. 1072, Hospital License Changes.-AB** — **Sen. Rand**

III. **Other Business**

IV. **Adjournment**

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, April 13, 2005

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

FAVORABLE

S.B. **216** Coordination of Children's Services/Study.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

H.B. **45** Adult Protective Services TF/Collaborate.
Sequential Referral: None
Recommended Referral: None

H.B. **239** Smoking in Public Places/Local Health Dept.
Sequential Referral: None
Recommended Referral: None

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

S.B. **119** Ticket to Work/Medicaid Eligibility.
Draft Number: PCS35208
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None
Long Title Amended: No

S.B. **1072** Hospital License Changes.-AB
Draft Number: PCS55212
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 5

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, April 13, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 13, 2005, in Room 544 of the Legislative Office Building, with sixteen members present. Senator William R. Purcell, Co-Chair, presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. .

Senator Purcell introduced Representative Nye to present HB 45, *Adult Protective Services TF/Collaborate* to the Committee. He said that this bill came from the Aging Study Commission and directs the Department of Health and Human Services to collaborate with other stake holders for adult protective services and report findings to North Carolina Study Commission of Aging and guardianship laws; and a that committee has already been appointed. Senator Dannelly moved for a favorable report, and the bill passed.

Senator Cowell presented her bill, SB 489, *Cosmetic Art Definitions/Exam Facilities*. Senator Bingham asked if the bill made any changes in qualifications; the response was it did not. Senator Rand asked about locations, particularly in southeast N.C., and having examination facilities at community colleges. Senator Cowell responded that there is a shortage of rooms available at community colleges. Douglas Van Essen, Director of the Board, said that current facilities to serve the southeast are limited. Kristy Snuggs, who works with the cosmetology departments of the community colleges, said that classrooms are not available during the week that, some facilities had not been approached about being used, and that there is an $80 fee at community colleges vs. a $50 fee at private exam facilities. Senator Cowell said that it could be possible to work with community colleges to find additional options there. She asked to remove the bill from the consideration, to bring it back at a later date.

Representative Wainwright presented HB 239, *Smoking in Public Places/Local Health Dep.* Senator Jacumin inquired if this bill was too restrictive in terms of distance, and Representative Wainwright responded that the 50 feet mentioned in the bill would help local health departments in obtaining federal grant funding. Senator Rand moved for a favorable report and the bill passed.

Senator Nesbitt brought his bill, SB 216, *Coordination of Children's Services/Study* to the Committee. Senator Kinnaird expressed her approval of the bill, as did Senator Berger. Senator Dannelly moved for a favorable report, and the bill passed and was referred to Appropriations.

Senator Rand presented his bill, SB 1072, *Hospital License Changes.-AB*. A motion for a Proposed Committee Substitute was presented and passed. Senator Bingham asked who is on the Medical Care Commission. Jeff Horton with the Division of Facility Services said that his Division staffs that Commission, which is appointed by the Governor. Senator Nesbitt asked about designating rural hospitals in metropolitan areas. Serge Dihoff from the Office of Rural Health replied that this designation is federally based on the ten-year census, and pertains to critical access hospitals. Senator Dannelly moved for an unfavorable report as to the original bill, favorable as to the Proposed Committee Substitute.

Senator Purcell asked Senator Bingham to chair while he explained SB 119. A motion for a Proposed Committee Substitute was brought forward, and passed. Senator Nesbitt asked for the dollar amount of the 100 percent cost of Medicaid. Andy Wilson with the Division of Medical Assistance said that that had not yet been worked out. Senator Nesbitt proposed an amendment that the premium be based on the experience of all individuals participating in the Medical Assistance Program. The amendment passed and was rolled into a new Proposed Committee Substitute. Senator Berger asked for the number of people this bill would help out. Janet Schanzenbach, Deputy Director of the NC Council of Community Programs estimated about 150 to 200 people in the first half year. Senator Hartsell moved for an unfavorable report as to the original bill, favorable as to the second Proposed Committee Substitute with the amendment included.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

HOUSE BILL 45*

Short Title:	Adult Protective Services TF/Collaborate.	(Public)
Sponsors:	Representatives Nye, Clary (Primary Sponsors); Weiss, Wilson, Alexander, Barnhart, Bordsen, Brown, Crawford, Earle, Farmer-Butterfield, Glazier, Langdon, Lewis, and McGee.	
Referred to:	Aging.	

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADULT PROTECTIVE SERVICES TASK FORCE TO COLLABORATE WITH OTHERS INTERESTED IN IMPROVING ADULT PROTECTIVE SERVICES AND REPORT, 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, Adult Protective Services Task Force, shall collaborate with stakeholders and other persons interested in improving adult protective services and report its findings and recommendations to the North Carolina Study Commission on Aging and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

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

HOUSE BILL 45:
Adult Protective Services TF/Collaborate

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Representative Nye
Date:	April 13, 2005	**Summary by:**	Shawn Parker
Version:	First Edition		Committee Staff

SUMMARY: ***House Bill 45 directs the Adult Protective Services Task Force to collaborate with others interested in improving adult protective services and report on or before April 1, 2006. This bill is a recommendation from the North Carolina Study Commission on Aging.***

BILL ANALYSIS:

House Bill 45 directs the Department of Health and Human Services, Adult Protective Services Task Force, to collaborate with stakeholders and other persons interested in improving adult protective services. The Task Force is directed to report findings and recommendations to the North Carolina Study Commission on Aging and the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

This bill would become effective when it becomes law.

BACKGROUND:

On December 1, 2004, the North Carolina Study Commission on Aging heard a presentation on issues related to the adult protective services system including: a historical perspective on the topic; the differences between elder mistreatment, elder abuse, elder neglect, and self-neglect in the context of North Carolina adult protective services; and a suggestion for a coalition to help with formal training. The Commission found that review of and changes to the adult protective services system are likely to be necessary to ensure that older adults are protected from abuse and neglect.

The Commission also recognizes that several groups are already reviewing the adult protective services system, and that collaboration would be helpful in determining what improvements could be made to the system. Efforts to study issues related to adult protective services include the following:

- The Department of Health and Human Services, in conjunction with the County Department of Social Services Directors' Association, has convened the Adult Protective Services (APS) Task Force. The Task Force has been working on ways to strengthen the adult protective services program and to improve quality, performance, and improved outcomes for county Departments of Social Services, and for the State, in an effort to carry out the statutory mandate to protect vulnerable adults. The task force has 28 members, including county DSS agencies and DHHS staff, and has taken a multi-pronged approach by looking at any needed statutory changes; administrative rule changes; workload, administration, and required training needs; policies and procedures; assessment tools, and community inter/intra relations i.e., how the community views our delivery of APS. Task Force members representing the county DSS agencies include: agency directors, program managers, supervisors, and line social workers, all of whom have responsibility for the delivery of APS at the local level. Short-term goals of the task force are to recommend

technical and clarifying changes to the law. Long-term goals include: the potential for recommendations involving more in-depth statutory changes, improved caseload management and additional training.

- The National Center on Elder Abuse, the National Committee for the Prevention of Elder Abuse (NCPEA), and the National Adult Protective Services Association are partnering to conduct a national study of elder abuse. Part of the study includes, "The 2004 Survey of Adult Protective Services Data," that intends to capture data from all 50 states. The initial survey deadline for the end of September has been extended to allow additional state response time. The purposes of the survey are to: establish a national data set for Adult Protective Services (APS); compare APS programs nationwide; measure APS interventions; demonstrate trends in the field of APS; and to bring national attention to the field. The University of Kentucky is conducting the research for NCPEA.

- S.L. 2004-161, Part 45, established a Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State law. Among the items the Commission is required to consider is a review of the State's adult protective services law. The Legislative Study Commission on State Guardianship Laws is required to make a final report to the 2006 Regular Session of the 2005 General Assembly upon its convening.

The North Carolina Study Commission on Aging recommended that the General Assembly direct the Adult Protective Services Task Force to collaborate with stakeholders and other persons interested in improving the adult protective services and report its findings and recommendations to the Study Commission on Aging and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

Legislative Analyst Theresa Matula contributed to this Summary.

H45-SMSQ-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 119

Short Title:	Ticket to Work/Medicaid Eligibility.	(Public)
Sponsors:	Senators Purcell, Dannelly, Hartsell; Albertson, Allran, Atwater, Bingham, Boseman, Dorsett, Forrester, Garwood, Holloman, Jenkins, Kerr, Kinnaird, Lucas, Malone, Rand, Snow, Soles, and Swindell.	
Referred to:	Health Care.	

February 14, 2005

A BILL TO BE ENTITLED

AN ACT TO EXPAND MEDICAID ELIGIBILITY TO INDIVIDUALS WHO QUALIFY UNDER THE FEDERAL TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF 1999, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The following individuals are eligible for Medicaid benefits under the State Medical Assistance Program:

(1) Individuals who are age 16 through 64 who are disabled and who are working, and

(2) Individuals who qualified for Medicaid under subdivision (1) of this section, but who lost eligibility for Medicaid under subdivision (1) of this section due to medical improvement, but who retain severe impairment.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of four hundred thousand dollars ($400,000) for the 2005-2006 fiscal year to support the expansion of Medicaid eligibility authorized under Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2005.

SENATE BILL 119:
Ticket to Work/Medicaid Eligibility

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Purcell
Date:	April 13, 2005	**Summary by:**	Dianna Jessup
Version:	PCS S119-PCS15225-LN-22		Committee Counsel

SUMMARY: ***Senate Bill 119 would expand Medicaid eligibility to persons who qualify under the federal Ticket To Work and Work Incentives Improvement Act of 1999, and would appropriate $150,000 for SFY 2006 to support this expansion. This is a recommendation of the Blue Ribbon Commission on Medicaid Reform. The new expansion would become effective January 1, 2007.***

The PCS differs from the original bill in that the PCS would specify, in statute, the eligibility and other requirements for participation in this program.

CURRENT LAW AND BACKGROUND: According to the Social Security Administration, the federal Ticket to Work and Work Incentive Improvement Act of 1999 (TWWIIA) does the following:

- Increases beneficiary choice in obtaining rehabilitation and vocational services to help them go to work and attain their employment goals;
- Removes barriers that require people with disabilities to choose between health care coverage and work; and
- Assures that more persons with disabilities have the opportunity to participate in the workforce and lessen their dependence on public benefits.

To encourage disabled persons to work, the Act allows states to expand Medicaid coverage (called the "buy-in") to persons who are 16 through 64, who are disabled, but who are working; and those disabled persons who are working and who lose eligibility due to medical improvement, but who retain a severe impairment. States have the option of setting any income or resource limit a state chooses and may require the disabled person to pay a fee or premium based on the person's income. Without this Medicaid buy-in option, disabled persons who are on Medicaid could lose their Medicaid benefits if the disability improves and they go to work.

BILL ANALYSIS: The bill would establish a Medicaid buy-in program for workers with disabilities, as permitted under TWWIIA.

A person would be eligible for coverage if all of the following apply:

1. The person is between the ages of 16-65.

2. The person is disabled, without regard to the person's ability to engage in, or actual engagement in substantial gainful activity.

3. The person's unearned income (ex. SSDI) does not exceed 150% of the federal poverty level and countable resources do not exceed the resource limit for the minimum community spouse resource standard under federal law.

4. The person is employed, which is specifically defined under the bill.

Persons participating in this buy-in program who have countable income great than 150% of the federal poverty level would pay an annual enrollment fee of $50 to their county department of social services.

Persons participating in the program who have a countable income of 200% of the federal poverty level would pay a monthly premium in addition to the annual fee. The premium would be based on a sliding scale set by the Department of Health and Human Services. Persons with countable income equal to or greater than 450% of the federal poverty level would pay 100% of the cost of the premium. All persons participating in the program would be subject to the same co-payments as those persons in the NC Health Choice program.

The bill would also appropriate $150,000 for the 2006-2007 fiscal year to support the Medicaid expansion authorized under the bill. According to the Medicaid Blue Ribbon Commission report, the initial total cost of the program is estimated to be $1.2 million, and after several years of implementation, the program may have a total cost of $45 million in health care expenditures for recipients. The actual cost will depend on the participation rate by adults with disabilities.

2005 Federal Poverty Guidelines, for family of one:

100% = $9,570

150% = $14,355

200% = $19,140

450% = $43,065

S119-SMSW-001

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 4/13/05

S. B. No. 119 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓ ~~S~~ LN-22

Rep.)
(Sen.)) Nesbett

moves to amend the bill on page 3, line 7

( ) WHICH CHANGES THE TITLE

by inserting after the phrase "Department." the following:

"The premium shall be based on the experience of all individuals participating in the Medical Assistance Program."

SIGNED Martha Nesbett

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

SENATE
COMMITTEE SUBSTITUTE

GENERAL ASSEMBLY OF NORTH CAROLINA APR 13 2005

SESSION 2005

S

ADOPTED

SENATE BILL 119
PROPOSED COMMITTEE SUBSTITUTE S119-PCS35208-SW-19

Short Title: Ticket to Work/Medicaid Eligibility. (Public)

Sponsors:

Referred to:

February 14, 2005

A BILL TO BE ENTITLED

AN ACT TO EXPAND MEDICAID ELIGIBILITY TO INDIVIDUALS WHO QUALIFY UNDER THE FEDERAL TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF 1999, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-54.1. Medicaid buy-in for workers with disabilities.**

(a) Title. – This act may be cited as the Health Coverage for Workers With Disabilities Act. The Department shall implement a Medicaid buy-in eligibility category as permitted under P.L. 106-170, Ticket to Work and Work Incentives Improvement Act of 1999. The Department shall establish rules, policies, and procedures to implement this act in accordance with this section.

(b) Definitions. – As used in this section, unless the context clearly requires otherwise:

(1) 'FPG' means the federal poverty guidelines.

(2) 'HCWD' means Health Coverage for Workers With Disabilities.

(3) 'SSI' means Supplemental Security Income.

(4) 'Ticket to Work' means the Ticket to Work and Work Incentives Improvement Act of 1999.

(c) Eligibility. – An individual is eligible for HCWD if:

(1) The individual is at least 16 years of age and is less than 65 years of age;

(2) The individual meets Social Security Disability criteria, or the individual has been enrolled in HCWD and then becomes medically improved as defined in Ticket to Work and as further specified by the Department. An individual shall be determined to be eligible under this

section without regard to the individual's ability to engage in, or actual engagement in, substantial gainful activity as defined in section 223 of the Social Security Act (42 U.S.C. § 423(d)(4)). In conducting annual redetermination of eligibility, the Department may not determine that an individual participating in HCWD is no longer disabled based solely on the individual's participation in employment or earned income;

(3) The individual's unearned income does not exceed one hundred fifty percent (150%) of FPG, and countable resources for the individual do not exceed the resource limit for the minimum community spouse resource standard under 42 U.S.C. § 1396r, and as further determined by the Department. In determining an individual's countable income and resources, the Department may not consider income or resources that are disregarded under the State Medical Assistance Plan's financial methodology, including the sixty-five dollar ($65.00) disregard, impairment-related work expenses, student earned-income exclusions, and other SSI program work incentive income disregards; and

(4) The individual is engaged in a substantial and reasonable work effort (employed) as provided in this subdivision and as further defined by the Department and allowable under federal law. For purposes of this subsection, "engaged in substantial and reasonable work effort" means all of the following:

a. Working in a competitive, inclusive work setting, or self-employed.

b. Earning at least the applicable minimum wage.

c. Having monthly earnings above the SSI basic sixty-five dollar ($65.00) earned-income disregard.

d. Being able to provide evidence of paying applicable Medicare, Social Security, and State and federal income taxes.

The Department may impose additional earnings requirements in defining "engaged in substantial and reasonable work effort" for individuals who are eligible for HCWD based on medical improvement.

Individuals who participate in HCWD but thereafter become unemployed for involuntary reasons, including health reasons, shall have continued eligibility in HCWD for up to 12 months from the time of involuntary unemployment, so long as the individual (i) maintains a connection with the workforce, as determined by the Department, (ii) meets all other eligibility criteria for HCWD during the period, and (iii) pays applicable fees, premiums, and co-payments.

(d) Fees, Premiums, and Co-Payments. – Individuals who participate in HCWD and have countable income greater than one hundred fifty percent (150%) of FPG shall pay an annual enrollment fee of fifty dollars ($50.00) to their county department of

social services. Individuals who participate in HCWD and have countable income greater than or equal to two hundred percent (200%) of FPG shall pay a monthly premium in addition to the annual fee. The Department shall set a sliding scale for premiums, which is consistent with applicable federal law. An individual with countable income equal to or greater than four hundred fifty percent (450%) of FPG shall pay not less than one hundred percent (100%) of the cost of the premium, as determined by the Department. The premium shall be based on the experience of all individuals participating in the Medical Assistance Program. Individuals who participate in HCWD are subject to co-payments equal to those required under the North Carolina Health Choice Program."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of one hundred fifty thousand dollars ($150,000) for the 2006-2007 fiscal year to support the expansion of Medicaid eligibility authorized under Section 1 of this act.

SECTION 3. Section 2 of this act becomes effective July 1, 2006. Section 1 of this act becomes effective January 1, 2007. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 239
Second Edition Engrossed 3/22/05

Short Title:	Smoking in Public Places/Local Health Dept.	(Public)
Sponsors:	Representatives Wainwright; B. Allen and England.	
Referred to:	Health.	

February 16, 2005

A BILL TO BE ENTITLED

AN ACT TO EXEMPT FROM THE LAW GOVERNING SMOKING RESTRICTIONS LOCAL HEALTH DEPARTMENTS AND THE BUILDINGS AND GROUNDS WHERE THEY ARE LOCATED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-599 reads as rewritten:

"**§ 143-599. Exemptions.**

All of the following facilities shall be exempt from the provisions of this Article:

(1) Any primary or secondary school or child care center, except for a teacher's lounge.

(2) An enclosed elevator.

(3) Public school bus.

(4) Hospital, nursing home, rest home, and State facility operated under the authority of G.S. 122C-181.

(5) Local health ~~department.~~department and the building and grounds where the local health department is located. For the purposes of this subdivision, "grounds" means the area located within 50 linear feet of a local health department.

(6) Any nonprofit organization or corporation whose primary purpose is to discourage the use of tobacco products by the general public.

(7) Tobacco manufacturing, processing, and administrative facilities."

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

HOUSE BILL 239:
Smoking in Public Places/Local Health Dept.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Representatives Wainwright, Allen and England
Date:	April 13, 2005		
Version:	Second Edition	**Summary by:**	Ben Popkin Committee Counsel

SUMMARY: ***House Bill 239 would exempt local health departments and the buildings and grounds of the departments from current laws governing smoking restrictions. This act would allow local health departments to ban smoking from the department itself, the building in which they are located and the entirety of their grounds. The second edition of the act defined "grounds" as the area 'located within 50 linear feet of a local health department'. This act would be effective when it becomes law.***

CURRENT LAW: Article 64 of the General Statutes addresses the needs and concerns of both smokers and nonsmokers in public places by providing for designated smoking and nonsmoking areas[1]. A list of buildings owned, leased or occupied by state government which may be designated as nonsmoking areas is set forth, including: museums, libraries, UNC health services facilities. Nonsmoking areas must be visibly posted as such, and requirements for separate ventilation systems and physical barriers between nonsmoking and adjacent smoking areas are provided for in the statute[2].

Violation by continuing to smoke in a nonsmoking area after having been given notice to stop smoking is an infraction punishable by a fine of not more than $25.00[3]. Local ordinances, laws or rules passed on or after October 15, 1993 regulating smoking may not contain restrictions exceeding those of Article 64 and may only address smoking in specifically identified types of facilities[4]. An itemized list of facilities is specifically exempted from regulation by the provisions of Article 64 and includes the following: any primary or secondary school, child care center (teacher's lounge excepted), enclosed elevators, public school buses, hospitals, nursing homes, rest homes, local health departments, organizations intended to discourage tobacco use, and tobacco manufacturing, processing and administrative facilities[5].

BILL ANALYSIS: This bill would clarify and expand the coverage of the exemption in G.S. 143-599(5). Rather than limiting the exemption to the premises of the local health department, as is currently the case, the bill would exempt the entire building and grounds where a local health department is located. The effect of this bill would be that in situations where the health department shares a building with another organization or individual, the entire building and grounds would be able to be designated as nonsmoking, if the appropriate agency or person in charge would like to give it that designation. For the purposes of G.S. 143-599, "grounds" means the area located within 50 linear feet of a local health department.

[1] G.S. 143-595.
[2] G.S. 143-597(b) & (c).
[3] G.S. 143-598.
[4] G.S. 143-601(b).
[5] G.S. 143-599.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 216

Short Title:	Coordination of Children's Services/Study.	(Public)
Sponsors:	Senators Nesbitt, Swindell, Allran, Dannelly, Lucas, Purcell; Hartsell, and Thomas.	
Referred to:	Health Care.	

February 24, 2005

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE COORDINATION OF SERVICES TO CHILDREN, YOUTH, AND FAMILIES BY CREATING CHILDREN'S SERVICES WORK GROUPS, BY ESTABLISHING AN INDEPENDENT STUDY COMMISSION TO MAKE RECOMMENDATIONS ON HOW TO ELIMINATE BARRIERS TO COLLABORATION BETWEEN AND AMONG CHILD-SERVING AGENCIES, AND TO MAKE AN APPROPRIATION AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"**Chapter 143C.**

"**Coordination of Children's Services.**

"**§ 143C-1. Intent; purpose.**

It is the intent of the General Assembly to (i) improve the safety and well-being of North Carolina's children, youth, and families; (ii) support collaboration between State, regional and local agencies that deliver services to children, youth, and families; (iii) make more effective use of existing federal, State, and local resources and programs for children, youth, and families; and (iv) streamline service delivery, fill service gaps, and eliminate duplication of services for children, youth, and families.

The Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts, and other affected State agencies share responsibility and accountability to assure effective collaboration among State and local agencies to improve outcomes for children and their families leading to full participation in their communities and schools."

SECTION 2.(a) The General Assembly recognizes that services to children, youth, and families are most effective when they are child- and family-centered, strengths-based, community-based, use multidisciplinary approaches, use evidence-based practices when appropriate, and recognize and respect cultural differences. These practices can be successfully implemented only where there is significant and ongoing collaboration and coordination between multiple public agencies. The General Assembly also recognizes that while agencies are making significant progress towards implementing these practices, there is also a need to focus State-level policy in order to provide support, remove barriers, and more fully implement these goals.

SECTION 2.(b) There is established a children's services work group. It shall be located in the Department of Administration for budgetary and staffing purposes only. The Secretary of the Department of Health and Human Services, the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chair of the State Board of Education, the Superintendent of Public Instruction, and the Chief Justice of the North Carolina Supreme Court shall each designate at least one representative to serve on the work group from among the programs, divisions, or departments under that administrator's control that provide services to children and youths. Each administrator named in the preceding sentence shall also appoint to serve on the work group at least one parent of a child or youth who has or is at risk for behavioral, social, health, or safety problems or academic failure, at least one member of a local collaborative body, and at least one private sector service provider. The Chair of the State Board of Education and the Superintendent of Public Instruction may make joint appointments.

SECTION 2.(c) The work group shall meet at least monthly. The first meeting of the work group shall occur not less than 30 days after the effective date of this section. The Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and the Administrative Office of the Courts shall, in this order and on a rotating basis, host the monthly meetings of the work group. The Department of Administration shall provide staff and clerical support to the work group.

SECTION 2.(d) The work group shall:

(1) Identify common outcome measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families, including preventative measures.

(2) Identify strategies for funding flexibility between State and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers.

(3) Develop a common service terminology to be used across child-serving agencies that is appropriate and assists collaboration and coordination.

(4) Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality.

(5) Develop mechanisms that would allow agencies to share information about individual children receiving multiple services. Any recommendations must take into account confidentiality requirements and be voluntary on the part of the party receiving services and time-limited. The mechanisms may address intake, assessment, and release procedures.

(6) Examine State and local training needs for implementing increased coordination and collaboration.

(7) Study other issues the work group determines would improve coordination and collaboration between child-serving agencies.

SECTION 2.(e) A majority of the work group shall constitute a quorum for the transaction of business.

SECTION 2.(f) Any member of the Council who is not an officer or employee of the State shall receive per diem and necessary travel and subsistence in accordance with the provisions of G.S. 138-5.

SECTION 2.(g) Upon the approval of the Secretary of the Department of Health and Human Services, the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chair of the State Board of Education, the Superintendent of Public Instruction, and the Chief Justice of the North Carolina Supreme Court, the work group shall submit its findings and recommendations to the Coordination of Children's Services Study Commission created under Section 4 of this act. The work group shall submit an interim report no later than December 15, 2005, and a final report no later than April 15, 2006. The reports shall specify those recommendations that may be implemented without statutory changes and those that would require statutory authorization.

If the General Assembly has not adjourned by those dates, or if the membership of the Study Commission has not been appointed, the work group shall submit its reports to the Joint Legislative Education Oversight Committee, the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee, the Joint Legislative Health Care Oversight Committee, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

The work group shall expire upon the filing of the final report.

SECTION 3. The Directors of the Bill Drafting, Research, and Fiscal Research Divisions of the General Assembly shall establish a children's services work group comprised of the legislative staff assigned to subject areas or agencies involving the child-serving programs administered by the Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Administrative Office of the Courts, and the Department of Public Instruction.

The work group shall: (i) monitor the proceedings of the children's services work group created under Section 2 of this act; (ii) provide information to legislators

and legislative bodies regarding the recommendations of the work group and methods by which the General Assembly may implement those recommendations; and (iii) provide a mechanism to improve coordination, collaboration, and education regarding children's services across State and local agencies among legislative staff.

This section shall expire upon the convening of the 2009 General Assembly. However, this shall in no way limit the Division Directors' authority to direct legislative staff to continue to implement the purposes of this section.

SECTION 4.(a) There is created the Coordination of Children's Services Study Commission ("Commission"). The Commission shall consist of 18 members appointed as follows:

(1) Nine members appointed by the Speaker of the House of Representatives as follows:
   a. Five members of the House of Representatives, of whom at least one shall also serve on the House of Representatives Health and Human Services Appropriations Subcommittee, at least one shall also serve on the House of Representatives Education Committee, at least one shall also serve on the House of Representatives Health Committee, and at least one shall also serve on a House of Representatives Judiciary Committee; and
   b. Four members of the public including a district court judge, a member of a local collaborative body, a private sector service provider, and a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure.

(2) Nine members appointed by the President Pro Tempore of the Senate as follows:
   a. Five members of the Senate of whom at least one shall also serve on the Senate Health and Human Services Appropriations Subcommittee, at least one shall also serve on the Senate Education Committee, at least one shall also serve on the Senate Health Committee, and at least one shall also serve on a Senate Judiciary Committee; and
   b. Four members of the public including a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a member of a local board of education, and a member of a board of county commissioners.

The Speaker of the House of Representatives shall appoint a cochair and the President Pro Tempore of the Senate shall appoint a cochair for the Commission. The Commission may meet at anytime upon the joint call of the cochairs. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment.

SECTION 4.(b) The purpose of the Commission is to study and recommend changes to improve collaboration and coordination between agencies that provide services to children, youth, and families with multiple service needs. The Commission's recommendations shall include mechanisms for establishing clear State leadership, consistent policy direction, and increased accountability at the State and local level. As part of its work, the Commission shall:

(1) Identify existing State, regional, and local collaborative bodies (including their charges, scopes of authority, and accountability requirements) that have been created by legislation, administrative rule, or agency policy and that are charged with serving, protecting, or improving the well-being of North Carolina's children, youth, and families. Once it has identified the collaborative bodies, the Commission shall consider how they could be consolidated, reorganized, or eliminated in order to improve their effectiveness and accountability, increase the likelihood that key players will actively participate, and reduce unnecessary duplication of effort. The Commission shall also consider the creation of a mechanism for coordination and communication between the State and local collaborative bodies, incentives for collaboration, clarification of roles among agencies, and ways to monitor the extent to which groups are collaborating.

(2) Study the practices of agencies currently implementing a system of care platform of practices and make recommendations regarding whether to adopt those practices statewide and across child-serving agencies as the preferred mechanism for providing services to children, youth, and families. In examining this issue, the Commission shall identify those State and local agencies that are currently implementing practices that are consistent with a system of care, those states that have implemented system of care as a statewide policy initiative, and the extent to which system of care is cost-effective.

(3) The Commission shall also examine the following principles that are associated with a system of care and determine whether to recommend the adoption of a State policy that reflects these principles:

a. Services for children should promote success, safety, and permanence.

b. Services should be child- and family-centered giving priority to keeping children with their families, in their home, school, and community.

c. Services should actively promote early identification and intervention.

d. Services should be designed to protect the rights of children.

e. Services shall be integrated and comprehensive, addressing the child's physical, educational, social, and emotional needs through a single child and family team.

f. Services shall be outcomes-accountable and tied to a unified child and family plan.
g. Agency resources and services shall be shared and coordinated.
h. Services shall be provided as close to home as appropriate in the least restrictive setting consistent with what is known to be effective.
i. Services shall be culturally competent.
j. Services shall address the unique strengths, needs, and potential of each child and family, and shall be sufficiently flexible to meet highly individualized child and family needs.
k. Management of the child-serving system is a responsibility shared among all public and private child-serving agencies that should be held collectively accountable for outcomes.

(4) In reviewing principles relating to system of care, the Commission shall determine whether they articulate goals that are measurable and if not, determine whether they could be modified to reflect measurable goals.

(5) Receive and study the recommendations contained in the reports submitted by the work group created in Section 2 of this act and determine whether to recommend any of the statutory proposals.

(6) Study any other issues the Commission determines would improve coordination and collaboration between child-serving agencies.

SECTION 4.(c) Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional and clerical staff to assist in the work of the Commission. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Supervisors of Clerks. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission. The members of the Commission, while in the discharge of official duties, may exercise all the powers provided under the provisions of G.S. 120-19 through G.S. 120-19.4, including the power to request all officers, agents, agencies, and departments of the State to provide any information, data, or documents within their possession, ascertainable from their records, or otherwise available to them, and the power to subpoena witnesses. Members of the Commission shall receive per diem, subsistence, and travel allowances at the rate established in G.S. 120-3.1, 138-5, or 138-6 as appropriate.

SECTION 4.(d) The Commission shall submit an interim report to the 2006 Regular Session of the 2005 General Assembly that contains its recommendations and legislative proposals. It shall submit a final report to the 2007 Regular Session of the 2007 General Assembly. Upon the earlier of the filing of its final report or the convening of the 2007 General Assembly, the Commission shall terminate.

SECTION 5. There is appropriated from the General Fund to the Department of Administration the sum of one hundred ten thousand dollars ($110,000) for the 2005-2006 fiscal year to carry out the provisions of this act.

SECTION 6. Section 5 of this act becomes effective July 1, 2005. The remainder of the act is effective when it becomes law.

SENATE BILL 216:
Coordination of Children's Services/Study

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Nesbitt
Date:	April 13, 2005	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 216 would create Chapter 143C entitled "Coordination of Children's Services". It states that the intent of the General Assembly is to improve services to children, support collaboration among agencies, make more effective use of resources, and streamline service delivery. It also states that child-serving agencies share responsibility and accountability for improving outcomes for children and families. In addition, the bill would create a children's services work group housed in the Department of Administration, a work group for legislative staff assigned to child servicing agencies and subject areas, and a study commission on the coordination of children's services.***

The bill would appropriate $110,000 to the Department of Administration for the 2005-2006 fiscal year to implement the provisions of this act.

Section 5(the appropriation) would become effective July 1, 2005. The remainder of the act would become effective when it becomes law.

The bill is serially referred to Appropriations.

CURRENT LAW: There are a number of entities created at the State level that are charged with overseeing services to children, youth and families. However, these groups tend to be charged with issues related to specific populations or services, such at prevention of juvenile delinquency (the Governor's Advisory Council on Juvenile Justice and Delinquency Prevention), early childhood development (Partnership for Children), or education (the Education Cabinet). There are also numerous local collaborative entities that reflect their State-level counterparts, such as the Juvenile Crime Prevention Councils. However, there is no governmental entity charged with the over-arching responsibility of coordinating children's services across age, agencies and disciplines.

The need for coordination and collaboration is recognized and is being implemented by many agencies under Memorandums of Agreement or Memorandums of Understanding (MOAs or MOUs). For example, the Department of Health and Human Services (DHHS), the Department of Public Instruction (DPI), the Department of Juvenile Justice and Delinquency Prevention (DJJDP), and the Administrative Office of the Courts (AOC) have entered into a MOA regarding the Comprehensive Treatment Services Program (CTSP) for children at-risk for institutionalization or other out of home placement. The MOA is required by law and must exist before CTSP funds can be made available (S.L. 2001-424, Sec. 21.60.(d)). Similarly, DHHS may not allocate CTSP funds at the local level until an MOA between the local counterparts of these agencies is in place. MOAs and MOUs also exist between DPI and DHHS regarding the provision of services to exceptional children, between DJJDP and local mental health programs regarding residential services to at-risk children in need of mental health and substance abuse treatment, and between local mental health programs and county departments of social services regarding their roles in providing for the safety, permanency and well-being of children.

BILL ANALYSIS:

Section 1 adds a new Chapter 143C entitled "Coordination of Children's Services". It states that it is the intent of the General Assembly to improve the well-being of North Carolina's families and children, support collaboration among agencies, make more effective use of existing resources and streamline service delivery. It also states that DHHS, DJJDP, DPI, AOC and other affected State agencies share responsibility and accountability to assure effective collaboration among State and local agencies to improve outcomes for children and their families leading to full participation in their schools and communities.

Section 2 begins by stating that the General Assembly recognizes that services to children, youth and families are most effective when they are child and family-centered, strengths-based, community-based, use multidisciplinary approaches, use evidence-based practices when appropriate, and recognize cultural differences. It also recognizes that agencies have made significant progress with collaboration, but there is also a need for State-level leadership to provide support, remove barriers and more fully implement the goals.

The legislation goes on to create a children's services work group. The work group is made up of appointees designated by the Secretaries of DHHS and DJJDP, the Superintendent of Public Instruction, the Chair of the State Board of Education, and the Chief Justice of the Supreme Court. The appointees consist of agency employees, parents of at-risk children, members of local collaborative bodies, and private providers.

The work group will be housed in the Department of Administration for budgetary and administrative purposes only. The DOA shall provide administrative and clerical support. The work group shall meet at least monthly, with each of the named agencies hosting the meetings on a rotating basis. The work group is charged with studying and making recommendations on specific issues that have been identified as barriers to interagency collaboration. These include:

- Identifying common outcome measures to monitor child health, safety and well-being;
- Identifying flexible funding strategies;
- Developing a common service terminology;
- Making recommendations regarding the creation of a shared database to track outcomes;
- Making recommendations regarding a mechanism for sharing individual information among agencies while protecting confidentiality; and
- Examining State and local training needs.

Subject to the approval of the various agency heads, the work group will make an interim report no later than December 15, 2005, and a final report no later than April 15, 2006. The reports will come to the Coordination of Children's Services Study Commission (if it is constituted), or the Oversight Committees for Education, Mental Health, Health Care, and Corrections, Crime Control and Juvenile Justice. The work group will terminate upon the submission of its final report.

Section 3 directs the Directors of the Bill Drafting, Research, and Fiscal Research Divisions of the General Assembly to create a children's services work group comprised of the legislative staff who are assigned to subject areas or agencies involving child-serving programs administered by DHHS, DJJDP, DPI, and AOC. The work group shall monitor the work of the agency work group created under Section 2 of the bill, provide information to legislators regarding the recommendations of that work group, and

create a mechanism for better coordination, collaboration and education regarding children's services among legislative staff. The legislative staff children's services work group will expire upon the convening of the 2009 General Assembly.

Section 4 creates the Coordination of Children's Services Study Commission ("Commission"). The Commission shall consist of 18 members, 9 appointed by the President Pro Tempore of the Senate and 9 appointed by the Speaker of the House of Representatives.

The President Pro Tempore's appointees will include five legislators, at least one of whom also serves on the Senate Health and Human Services Appropriations Subcommittee, at least one of whom also serves on the Senate Education Committee, at least one of whom also serves on the Senate Health Committee, and at least one of whom also serves on a Senate Judiciary Committee. The four public members appointed by the President Pro Tempore will include a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a member of a local board of education, and a member of a board of county commissioners.

The Speaker's appointees will include five legislators, at least one of whom also serves on the House Health and Human Services Appropriations Subcommittee, at least one of whom also serves on the House Education Committee, at least one of whom also serves on the House Health Committee, and at least one of whom also serves on a House Judiciary Committee. The four public members appointed by the Speaker include a district court judge, a member of a local collaborative body, a private sector service provider, and a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure.

The purpose of the Commission is to study and recommend changes to improve collaboration and coordination among agencies that provide services to children, youth and families with multiple service needs, including mechanisms for establishing clear State leadership, consistent policy direction, and increased accountability at the State and local level. The Commission shall:

- look at existing conflicting and overlapping collaborative entities and make recommendations regarding their consolidation, reorganization or elimination;
- examine agencies that are implementing a system of care as the model for delivering services and determine whether to adopt a system of care across agencies as the preferred method of service delivery in the State; and
- review the recommendations of the children's services work group.

The Commission shall submit an interim report to the 2006 Regular Session of the 2005 General Assembly, and a final report upon the convening of the 2007 General Assembly. The Commission shall terminate upon the filing of its final report.

Section 5 appropriates $110,000 from the General Fund to DOA for the 2005-2006 fiscal year to carry out the provisions of the act.

Section 5 becomes effective July 1, 2005. The remainder of the act becomes effective when the act becomes law.

BACKGROUND: The Studies Act of 2004 directed the co-chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to study the integration of care for children with multiple service needs. S.L. 2004-161, Sec. 24.2. After numerous meetings with agency heads, the co-chairs of the State Collaborative, and representatives from several local collaboratives ("work group"), LOC co-chairs brought the work group's recommendations to the LOC for review. The LOC included the substance of those recommendations in this bill draft.

S216-SMSS-001

Research Division staff Kory Goldsmith and Shirley Iorio contributed significantly to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 489

Short Title:	Cosmetic Art Definitions/Exam Facilities.	(Public)
Sponsors:	Senators Cowell, Kerr; and Snow.	
Referred to:	Health Care.	

March 15, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS TO CLARIFY CERTAIN DEFINITIONS UNDER THE NORTH CAROLINA COSMETIC ART ACT, TO APPROVE EXAMINATION FACILITIES, AND TO SET LIMITS FOR FAILED CANDIDATES SEEKING TO RETAKE AN EXAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88B-2 reads as rewritten:

"**§ 88B-2. Definitions.**

The following definitions apply in this Chapter:

(1) Apprentice. – A person who is not a manager or operator and who is engaged in learning the practice of cosmetic art under the direction and supervision of a cosmetologist.

(2) Board. – The North Carolina Board of Cosmetic Art Examiners.

(3) Booth. – A workstation located within a licensed cosmetic art shop that is operated primarily by one individual in performing cosmetic art services for consumers.

(4) Booth renter. – A person who rents a booth in a cosmetic art shop.

(5) Cosmetic art. – All or any part or combination ~~of: (i) the systematic massaging with the hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, and marcelling the hair, and the use of electricity for stimulating growth of hair.~~of cosmetology, esthetics, or manicuring.

(6) Cosmetic art school. – Any building or part thereof where cosmetic art is taught.

(7) Cosmetic art shop. – Any building or part thereof where cosmetic art is practiced for pay or reward, whether direct or indirect.

(8) Cosmetologist. – Any individual who is licensed to practice all parts of cosmetic art.

(8a) Cosmetology. – The act of arranging, dressing, curling, waving, cleansing, cutting, singeing, bleaching, coloring, or similar work upon the hair of a person by any means, including the use of hands, mechanical or electrical apparatus, or appliances or by use of cosmetic or chemical preparations or antiseptics.

(9) Cosmetology teacher. – An individual licensed by the Board to teach all parts of cosmetic art.

(10) Esthetician. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes skin care.

(11) Esthetician teacher. – An individual licensed by the Board to teach only that part of cosmetic art that constitutes skin care.

(11a) Esthetics. – Refers to any of the following practices: giving facials; applying makeup; performing skin care; removing superfluous hair from the body of a person by use of depilatories, tweezers, or waxing; applying eyelashes to a person, including the application of brow or lash color; beautifying the face, neck, arms, or upper part of the human body by use of cosmetic preparations, antiseptics, tonics, lotions, or creams; surface massaging in relation to skin care; or cleaning or stimulating the face, neck, ears, arms, hands, bust, torso, legs, or feet of a person by means of hands, devices, apparatus, or appliances along with the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

(12) Manicuring. – The care and treatment of the fingernails, toenails, cuticles on fingernails and toenails, and the hands and feet, including the decoration of the fingernails and the application of nail extensions and artificial nails. The term "manicuring" shall not include the treatment of pathologic conditions.

(13) Manicurist. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes manicuring.

(14) Manicurist teacher. – An individual licensed by the Board to teach manicuring.

(15) Shampooing. – The application and removal of commonly used, room temperature, liquid hair cleaning and hair conditioning products. Shampooing does not include the arranging, dressing, waving, coloring, or other treatment of the hair."

SECTION 2. G.S. 88B-18 reads as rewritten:

"**§ 88B-18. Examinations.**

(a) Each applicant for any examination shall file an application with the Board, on a form approved by the Board, which shall be verified by the applicant under oath,

and the applicant shall pay the required examination fee. Applications shall be filed at least 30 days before the requested examination date.

(b) Each examination shall have both a practical and a written portion.

(c) Examinations for applicants for apprentice, cosmetologist, teacher, esthetician, and manicurist licenses shall be given in at least three locations in the State that are geographically scattered. The examinations shall be administered in ~~the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. The Board shall reimburse an institution, if requested, for the use of its facilities in administering examinations.~~Board-approved facilities.

(d) An applicant for a ~~cosmetologist~~ cosmetologist, esthetician, manicurist, or teacher's license who fails to pass the examination three times may not reapply to take the examination again until after the applicant has successfully completed any additional requirements prescribed by the Board."

SECTION 3. G.S. 88B-9 reads as rewritten:

"**§ 88B-9. Qualifications for licensing as an esthetician.**

The Board shall issue a license to practice as an esthetician to any individual who meets all of the following requirements:

(1) Successful completion of at least 600 hours of an ~~esthetician~~ esthetics curriculum in an approved cosmetic art school.

(2) Passage of an examination conducted by the Board.

(3) Payment of the fees required by G.S. 88B-20."

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

SENATE BILL 489:
Cosmetic Art Definitions/Exam Facilities

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senators Cowell and Kerr
Date:	April 11, 2005	**Summary by:**	Shawn Parker
Version:	1st edition		Committee Staff

SUMMARY: Senate Bill 489 amends the Cosmetic Art Act as follows:

- ***Clarifies the definition of Cosmetic Art.***
- ***Provides definitions for the terms "Cosmetology" and "Esthetics"***
- ***Authorizes the North Carolina Board of Cosmetic Art Examiners to approve facilities for licensure examination.***
- ***Expands certain examination provisions of the act to include manicurists, estheticians, and cosmetology teachers.***

CURRENT LAW: The practice of cosmetic art is regulated by a Board of Cosmetic Art Examiners. Cosmetic art is defined as all or any part or combination of: (i) the systemic massaging with hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, marcelling the hair, and the use of electricity for stimulating growth of hair. The terms cosmetology and esthetics are not defined.

Current law provides that cosmetology examinations must be administered in the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. If a cosmetology applicant fails the licensure examination three times, the applicant may not reapply to take the examination until the applicant successfully completes additional requirements.

BILL ANALYSIS: Senate Bill 489 would define cosmetic art as cosmetology, esthetics, or manicuring and would define cosmetology and esthetics as follows:

- "Cosmetology" would generally mean acts relating to hair cutting, coloring, or styling.
- "Esthetics" would generally mean acts relating to skin care and makeup, including waxing.

Senate Bill 489 also authorizes the Board to approve facilities for licensure examinations and expands the examination provision regarding reapplying for examination of the act to include manicurists, estheticians, and cosmetology teachers.

The act is effective when it becomes law.

S489-SMSQ-001

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1072

Short Title:	Hospital License Changes.-AB	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO CHANGE THE DEFINITION OF "PRIMARY CARE HOSPITAL" TO CONFORM TO FEDERAL CHANGES; TO AUTHORIZE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO SUSPEND ADMISSIONS OR SERVICES IN HOSPITALS AS PART OF TAKING ADVERSE ACTION AGAINST A HOSPITAL'S LICENSE; AND TO AUTHORIZE THE MEDICAL CARE COMMISSION TO ESTABLISH STAFF QUALIFICATIONS FOR HOSPITAL STAFF.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-76(1a) reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

...

(1a) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development. To be designated as a critical access hospital under this subdivision, the hospital must ~~meet the requirements of federal law for certification as a critical access hospital.~~be certified as a critical access hospital pursuant to 42 CFR Part 485 Subpart F."

SECTION 2. G.S. 131E-78 reads as rewritten:

"**§ 131E-78. Adverse action on a license.**

(a) The Department shall have the authority to deny, suspend, revoke, annul, withdraw, recall, cancel, or amend a license in any case when it finds a substantial failure to comply with the provisions of this Part or any rule promulgated under this Part.

~~(b) The Department shall conduct a hearing in accordance with Chapter 150A of the General Statutes, the Administrative Procedure Act, when:~~

~~(1) The Department denies an application and the applicant requests a hearing; or~~

~~(2) The Department initiates proceedings under subsection (a).~~

~~(c) Any applicant or operator who is dissatisfied with the decision of the Department as a result of the hearing provided in this section and after a written copy of the decision is served, may request a judicial review under Chapter 150A of the General Statutes, the Administrative Procedure Act.~~

(b1) The Department may suspend the admission of any new patients to specific areas of a facility or suspend specific services of a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the patients. When the Department suspends admissions or specific services, the suspension shall be limited to the smallest possible components of the facility, and the Department shall provide consultation to assist the facility in correcting the conditions which led to the suspension in order that the suspension can be lifted at the earliest possible time and the Department is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions or services under this subsection, the Department 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 residents.

(c1) A facility may contest any adverse action on its license under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the adverse action, the facility must file a petition for a contested case within 20 days after the Department mails notice of the adverse action on the licensee."

SECTION 3. G.S. 131E-79 reads as rewritten:

"**§ 131E-79. Rules and enforcement.**

(a) The Commission shall ~~promulgate~~ adopt rules necessary to implement this Article. In addition, the Commission shall adopt rules to establish staff qualifications including professional requirements for hospital staff. The rules may require that one or more staff of a hospital be either licensed or certified. The rules may establish minimum training and education qualifications for staff and may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the North Carolina General Statutes provided that the professional certification board evaluates applicants on a basis which protects the public health, safety, or welfare.

(b) The Department shall enforce this Article and the rules of the Commission."

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

SENATE BILL 1072:
Hospital License Changes

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Rand
Date:	April 13, 2005	**Summary by:**	Shawn Parker
Version:	S1072-CSSQ-4		Committee Staff

SUMMARY: ***Senate Bill 1072 amends the Hospital Licensure Act by making changes to the definition of "critical access hospitals", by authorizing the Secretary of the Department of Health and Human Services to suspend admissions or services in hospitals, and by authorizing the Medical Care Commission to establish staff qualifications for hospital providers.***

The Proposed Committee Substitute makes changes to the definition of "Critical Access Hospitals" in Section 1, rewrites subsection (b1) in Section 2. The act would become effective when it becomes law.

BILL ANALYSIS:

Senate Bill 1072 amends the definition of critical access hospital by authorizing the Department of Health and Human Services, Office of Research and Development to designate hospitals in federally designated Metropolitan Statistical Areas as "rural hospitals" for the purpose of the critical access hospital program, if the hospital is located in a county that has twenty-five percent or greater rural residents as defined by the most recent decennial census. This language establishes a statutory process for designating rural hospitals as provided in 42 CFR Part 485 Subpart F and affects Critical Access Hospitals in Davie, Yadkin, Chatham, Alexander, Stokes and Pender County.

Senate Bill 1072 also authorizes the Secretary of the Department of Health and Human Services to suspend admissions in a hospital or a particular service or unit of a hospital where conditions are considered dangerous to the health and safety of its patients after considering the following factors:

- The character and degree of impact the conditions have on a patient's health and safety
- The character and degree of impact the suspension would have on the functionality of the hospital and its ability to serve current patients and the community
- If all other reasonable means for correcting the problem have been exhausted

Additionally, the bill requires the Department to provide consultation in assisting the hospital to correct the conditions that caused the suspension and provides for the hospital to contest the adverse action by filling a petition within 20 days after the Department mails the notice of adverse action on the license. Currently, the Department's only response when conditions in a hospital are dangerous to the health and safety of the patients is to downgrade the license to provisional status or revoke the license.

Finally, Senate Bill 1072 amends rule-making authority to allow the North Carolina Medical Care Commission to establish staff qualifications including professional requirements for hospital providers.

Effective when it becomes law.

S1072-SMSQ-001

SENATE
COMMITTEE SUBSTITUTE

APR 13 2005

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S

ADOPTED

SENATE BILL 1072
PROPOSED COMMITTEE SUBSTITUTE S1072-PCS55212-SQ-4

Short Title: Hospital License Changes.-AB (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO CHANGE THE DEFINITION OF "CRITICAL ACCESS HOSPITAL" TO CONFORM TO FEDERAL CHANGES; TO AUTHORIZE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO SUSPEND ADMISSIONS OR SERVICES IN HOSPITALS AS PART OF TAKING ADVERSE ACTION AGAINST A HOSPITAL'S LICENSE; AND TO AUTHORIZE THE MEDICAL CARE COMMISSION TO ESTABLISH STAFF QUALIFICATIONS FOR HOSPITAL STAFF.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-76(1a) reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

...

(1a) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development. To be designated as a critical access hospital under this subdivision, the hospital must ~~meet the requirements of federal law for certification as a critical access hospital.~~be certified as a critical access hospital pursuant to 42 CFR Part 485 Subpart F. The North Carolina Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development may designate a hospital located in a federally designated Metropolitan Statistical Area as a rural hospital for the purposes of the critical access hospital program if the hospital is located in a county with twenty-five percent (25%) or more rural

residents as defined by the most recent United States decennial census."

SECTION 2. G.S. 131E-78 reads as rewritten:

"**§ 131E-78. Adverse action on a license.**

(a) The Department shall have the authority to deny, suspend, revoke, annul, withdraw, recall, cancel, or amend a license in any case when it finds a substantial failure to comply with the provisions of this Part or any rule promulgated under this Part.

~~(b) The Department shall conduct a hearing in accordance with Chapter 150A of the General Statutes, the Administrative Procedure Act, when:~~

~~(1) The Department denies an application and the applicant requests a hearing; or~~

~~(2) The Department initiates proceedings under subsection (a).~~

~~(c) Any applicant or operator who is dissatisfied with the decision of the Department as a result of the hearing provided in this section and after a written copy of the decision is served, may request a judicial review under Chapter 150A of the General Statutes, the Administrative Procedure Act.~~

(b1) The Secretary may suspend the admission of any new patients to specific areas of a hospital or suspend specific services of a hospital licensed under this Article where the conditions of the hospital constitute a substantial failure to comply with the provisions of this Part or any rule adopted under this Part and are dangerous to the health or safety of the patients. When the Secretary suspends admissions or specific services, the suspension shall be limited to the smallest possible components of the hospital. The Department shall provide consultation to assist the hospital in correcting the conditions which led to the suspension in order that the suspension can be lifted at the earliest possible time that the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In determining whether to suspend admissions or services under this subsection, the Secretary shall consider the following factors:

(1) The character and degree of impact of the conditions at the hospital on the health and safety of its patients.

(2) The character and degree of impact that the proposed suspension of admissions or services would have on the functionality of the hospital and the availability of services necessary to the community or to current patients of the hospital.

(3) Whether all other reasonable means for correcting the problem have been exhausted, no less restrictive alternative to suspension of admissions or service exists.

(c1) A facility may contest any adverse action on its license under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the adverse action, the facility must file a petition for a contested case within 20 days after the Department mails notice of the adverse action on the licensee."

SECTION 3. G.S. 131E-79 reads as rewritten:

"**§ 131E-79. Rules and enforcement.**

(a) The Commission shall ~~promulgate~~ adopt rules necessary to implement this Article. In addition, the Commission shall adopt rules to establish staff qualifications including professional requirements for hospital staff. The rules may require that one or more staff of a hospital be either licensed or certified. The rules may establish minimum training and education qualifications for staff and may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the North Carolina General Statutes provided that the professional certification board evaluates applicants on a basis which protects the public health, safety, or welfare.

(b) The Department shall enforce this Article and the rules of the Commission."

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

VISITOR REGISTRATION

SENATE HEALTH CARE COMMITTEE APRIL 13, 2005

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charlene Carey	Elon University
Barbara Hoet	NCRTR
Michael Haley	DJJDP
Jeffrey Walton	YAIO
AL DEITCH	DOA
Andy Wilson	DHHS, DMA
Mary Freeman	TAMMY LYNN CENTER for Dev. Dis
DAVE SARONT	BRCS
Lorraine Thielmann	ESUCP
CL Cochran	ESUCP- C 2001
Chris Kiricoples	Beaufort County Developmental Center & NCARF
Serge Dihoff	NC Office of Rural Health

VISITOR REGISTRATION

SENATE HEALTH CARE COMMITTEE APRIL 13, 2005

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack Sasser	NC Council
Abby Emanuelson	NMSS
Joe Kennedy	~~DISABILITY RIGHTS~~
L Shutt	Doc of the Day
April Culver	Johnston Memorial Hospital
Joanne Steven	nursing
Stacy Flannery	NCHCFA
Patrick Buffkin	NCGA
Rebecca Tranter	NCACC
Joy Barton	DHHS - DFS
Steve Shore	NC Pediatric Society

VISITOR REGISTRATION

SENATE HEALTH CARE COMMITTEE APRIL 13, 2005

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stefanie Shore	NC Board of Cosmetic Art Exam
Douglas H. Van Essen	NC Board of Cosmetic Art Examiners
Patricia A. Yancey	APPCNC/NOD
Starla McKenney	NC DHHS
Lisa Reid	TCHC
Robin Huffman	NC Psychiatric Assoc/C2001

Senate Health Care Committee
Wednesday, April 20, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 326	Retired Nurses Return to Work.	Senator Bingham
HB 496	Student Asthma Medications.	Representative Harrison Representative Insko

Presentations

Other Business

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 326

Short Title:	Retired Nurses Return to Work.	(Public)
Sponsors:	Senators Bingham; Atwater, Brock, Brown, Clodfelter, Dannelly, Dorsett, Forrester, Garwood, Goodall, Hartsell, Holloman, Horton, Hunt, Jacumin, Jenkins, Kerr, Kinnaird, Lucas, Malone, Presnell, Rand, Smith, Stevens, and Tillman.	
Referred to:	Health Care.	

March 3, 2005

A BILL TO BE ENTITLED

AN ACT TO ENABLE RETIRED REGISTERED NURSES TO RETURN TO EMPLOYMENT TEACHING AT COMMUNITY COLLEGES WITHOUT LOSING RETIREMENT BENEFITS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-3(8)c. reads as rewritten:

"c. Should a beneficiary who retired on an early or service retirement allowance under this Chapter be reemployed, or otherwise engaged to perform services, by an employer participating in the Retirement System on a part-time, temporary, interim, or on a fee-for-service basis, whether contractual or otherwise, and if such beneficiary earns an amount during the 12-month period immediately following the effective date of retirement or in any calendar year which exceeds fifty percent (50%) of the reported compensation, excluding terminal payments, during the 12 months of service preceding the effective date of retirement, or twenty thousand dollars ($20,000), whichever is greater, as hereinafter indexed, then the retirement allowance shall be suspended as of the first day of the month following the month in which the reemployment earnings exceed the amount above, for the balance of the calendar year. The retirement allowance of the beneficiary shall be reinstated as of January 1 of each year following suspension. The amount that may be earned before suspension shall be increased on January 1 of each year by the

ratio of the Consumer Price Index to the Index one year earlier, calculated to the nearest tenth of a percent (1/10 of 1%).

The computation of postretirement earnings of a beneficiary under this sub-subdivision, G.S. 135-3(8)c., who has been retired at least six months and has not been employed in any capacity, except as a substitute teacher or a part-time tutor, with a public school for at least six months immediately preceding the effective date of reemployment, shall not include earnings while the beneficiary is employed to teach on a substitute, interim, or permanent basis in a public school. The Department of Public Instruction shall certify to the Retirement System that a beneficiary is employed to teach by a local school administrative unit under the provisions of this sub-subdivision and as a retired teacher as the term is defined under the provisions of G.S. 115C-325(a)(5a).

The computation of postretirement earnings of a beneficiary under this sub-subdivision, G.S. 135-3(8)c., who is a registered nurse with a masters degree in nursing, and who has been retired at least six months and has not been employed in any capacity by the State for at least six months immediately preceding the effective date of reemployment, shall not include earnings while the beneficiary is employed to teach nursing at a community college. The Department of Community Colleges shall certify to the Retirement System that a beneficiary is employed to teach by a community college under the provisions of this sub-subdivision and as a retired registered nurse.

Beneficiaries employed under this sub-subdivision are not entitled to any benefits otherwise provided under this Chapter as a result of this period of employment."

SECTION 2. This act becomes effective July 1, 2005.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, April 20, 2005

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

FAVORABLE

H.B.(CS #1) **496** Student Asthma Medications.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, April 21, 2005

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

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

S.B. **326** Retired Nurses Return to Work.

Draft Number:	PCS75293
Sequential Referral:	None
Recommended Referral:	Pensions & Retirement and Aging
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, April 20, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 20, 2005, in Room 544 of the Legislative Office Building, with eleven members present. Senator Stan Bingham presided. Senator Bingham and Senator William R. Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham introduced Representative Harrison to explain, House Bill 496, ***Student Asthma Medications***. A constituent who has children who are severely allergic and had moved here from Ohio brought the bill to Representative Harrison's attention. Upon arriving here she found that her children could no longer carry their anaphylaxis medication to school. There was federal legislation passed in October 2004 giving states an incentive to pass legislation that protects the students' rights to carry asthma and anaphylaxis medications. It does provide access to some grant money. NC is one of ten states that do not protect the students right to carry asthma medication. Senator Goodall stated he has an asthmatic daughter who was not allowed to carry her medication for a couple of years but she carried it anyway. Senator Allran sees the need for this bill but asked if the bill was modeled on other states legislation. Representative Harrison stated that section one of the bill tracks the federal legislation and said in order to compete for the grant money the state law to protect asthma medication should contain those elements. Senator Allran stated that if it went through the House with no opposition it must be pretty good. Senator Goodall moved for a favorable report. Senator Allran asked what anaphylaxis is. Senator Purcell stated it was a severe reaction brought on by allergies involving wheezing and difficult breathing and it can be deadly. Cindy Mosley, the mother of highly allergic children, stated that her child had been taught since he was three to administer his own medication. Ms. Mosley feels that her child would be safer with his medication, instead of it being locked in a file cabinet. Debra Bryan, President and CEO of the American Lung Association of NC, stated that we mandate our children go to school and today we have as many as 500,000 children suffering from asthma, but only about 170,000 of those are diagnosed. Ms. Bryan stated that asthma has a tremendous impact on our society. There has been a 55% increase in death rates from asthma in the last two decades and it is the leading cause of absenteeism from school. Senator Goodall had previously moved for a favorable report and the bill passed.

Senator Purcell took the chair for Senator Bingham who presented his bill, Senate Bill 326, ***Retired Nurses Return to Work***. Senator Bingham asked to pass out an amendment. Senator Purcell asked if the bill had a PCS and stated it had to go to the Pension & Retirement and Aging Committee. Senator Bingham stated there is not a PCS, just an amendment. The amendment amends the bill on page 2, lines 21 through 24. The original bill only included Community Colleges. The amendment expands the bill to

include the University Systems of NC. Senator Bingham asked if Joann Stevens could speak. Joann Stevens, representing the North Carolina Nurses Association, stated that the nursing faculty are aging out at a fast rate. The bill only speaks to Community College Nursing Faculty and the amendment expands it to University Faculty as well. There are nine University Nursing Programs in the state. Senator Bingham moved for the adoption of the amendment and it was adopted. Senator Bingham stated that the Community Colleges have a desperate need for teachers in the nursing program. If someone has retired from the state with a Masters Degree in Nursing and goes to work with the Community Colleges they will be penalized on their retirement. Therefore there are no incentives to teach at the Community Colleges. This bill states that nurses with Masters degrees can come back and teach at the Community Colleges and Universities Systems. Senator Dorsett asked if a retired nurse could return to a University as something other than a teacher. Senator Bingham stated it was just to teach. The shortage has been in teachers. Senator Goodall asked if it makes any difference if the teaching is part time or full time and would more money be withheld from the pay for retirement on the second income. Diana Jessup stated that the bill only speaks to earnings as opposed to part time verses full time. Pam Deardoff, with the State Retirement Division, stated this would be similar to the situation that allows retired members to come back in the teaching profession. There is an earnings cap on what you can make when you come back after having worked before. That is roughly about 50% of your salary so someone could work part time without meeting that earnings cap. This is for a full time position and offers an exemption to the retirement benefit that you can earn when you come back to employment. Ms. Deardoff does not think there is a second withdrawal of retirement on the second employment. Senator Forrester stated the need for a new fiscal note now that the amendment includes the Universities Systems. Senator Dannley moved for a favorable report, to roll the amendment into a Proposed Committee Substitute, favorable to PCS, unfavorable original bill with a recommendation that the bill be re-referred to Pension & Retirement and Aging. The bill passed.

The meeting was adjourned at 11:40 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chrisoce, Committee Assistant

SENATE BILL 326:
Retired Nurses Return to Work

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Bingham
Date:	April 20, 2005	**Summary by:**	Dianna Jessup
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 326 would permit retired registered nurses with masters degrees to return to employment teaching at community colleges without losing retirement benefits. The act would become effective July 1, 2005.***

Pursuant to Senate Rule 42.2(a)(2), this bill should be re-referred to the Committee on Pensions and Retirement and Aging.

CURRENT LAW: If a retired State employee returns to State employment, the employee may only earn the greater of 50% of the salary the employee was earning prior to retirement or $25,420 without being subject to a reduction of the employee's retirement benefits.

BILL ANALYSIS: Senate Bill 326 would remove this earnings restriction on any registered nurse with a masters degree who has been retired from the Teachers' and State Employees' Retirement System for at least six months and is reemployed to teach in a nursing program in the community college system.

BACKGROUND: A Nursing Workforce Taskforce, convened by the North Carolina Institute of Medicine (IOM), began meeting in February 2002 to look at ways to respond to the growing nursing shortage in the State. The 55-member task force included representatives from the NC Nursing Association, the NC Center for Nursing, the NC Board of Nursing, the NC Hospital Association, and the NC Area Health Education Centers (AHECs). There were also representatives from the NC Community College System, the University of North Carolina and NC Independent Colleges and Universities on the task force. The IOM Task Force developed findings and recommendations directed at each agency involved in either educating or hiring nurses; 23 of them specifically affect community colleges. One of the findings of the Task Force was that it has been hard to recruit masters level faculty in community college programs, especially in rural counties.

The Board of Governors has a Committee on the Future of Nursing. The Committee was charged to review the IOM Nursing Workforce Report and other information to address issues of nursing and make recommendations to the Board regarding the steps UNC nursing programs need to take to help North Carolina avoid a nursing shortage. The State Board of Community Colleges also has a similar committee.

S326-SMSW-001

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

Legislative Actuarial Note

RETIREMENT

BILL NUMBER: Senate Bill 326 (First Edition)

SHORT TITLE: Retired Nurses Return to Work.

SPONSOR(S): Senator Bingham

FUNDS AFFECTED: General Fund, Highway Fund, and Receipt Funds

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Retirement System

EFFECTIVE DATE: July 1, 2005

BILL SUMMARY: The present law provides for a cap on the amount of earnings that a re-employed retired employee may earn without reduction of the employee's retirement benefits. The earnable amount is the greater of either 50% of the salary the member was earning prior to retirement or $25,420. This bill removes the reemployed earnings restrictions on any nurse who is retired from the Teachers' and State Employees' Retirement System and is reemployed to teach in a nursing program with the community college system. To qualify, registered nurse must have been retired for at least six months and not employed in any capacity by the State for at least six months immediately preceding the effective date of reemployment.

ESTIMATED IMPACT: There is no available data that will reflect how many retired nurses will return to employment under this bill but both, Mellon, the Retirement System's actuary, and Hartman & Associates, the General Assembly's actuary, agree that the cost would be negligible.

ASSUMPTIONS AND METHODOLOGY: Teachers' & State Employees' Retirement System: The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the December 31, 2003 actuarial valuation of the fund. The data included 303,768 active members with an annual payroll of $10.1 billion and 123,077 retired members in receipt of annual pensions totaling $2.1 billion. Significant actuarial assumptions used include (a) an investment return rate of 7.25%, (b) salary increase rate of 6.25%, (c) the George B. Buck Mortality Tables for deaths in service and after retirement and (d) rates of separation from active service based on System experience. The actuarial cost method used was the entry age normal method with open-end unfunded accrued liability and a frozen unfunded liquidation period of nine years. Detailed information concerning these assumptions and methods is shown in the actuary's report, which is available upon request from Stanley Moore.

SOURCES OF DATA: System Actuary - Mellon
General Assembly Actuary - Hartman & Associates, LLC

TECHNICAL CONSIDERATIONS: The estimated cost is determined by using the assumed rates of retirement versus the actual rates of retirement for members of this group.

FISCAL RESEARCH DIVISION: (919) 733-4910. The above information is provided in accordance with North Carolina General Statute 120-114 and applicable rules of the North Carolina Senate and House of Representatives.

PREPARED BY: Stanley Moore

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

DATE: April 8, 2005

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 326

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

S326-ALT-1 [v.1]

Date _____,2005

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Senator Bingham

moves to amend the bill on page 2, lines 21 through 24, by rewriting the lines to read:

"community college or a constituent institution of The University of North Carolina. The Department of Community Colleges or the Board of Governors of The University of North Carolina, as applicable, shall certify to the Retirement System that a beneficiary is employed to teach by a community college or constituent institution of The University of North Carolina under the provisions of this sub-subdivision and as a retired registered nurse."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 496

Committee Substitute Favorable 3/28/05

Short Title: Student Asthma Medications. (Public)

Sponsors:

Referred to:

March 7, 2005

A BILL TO BE ENTITLED

AN ACT REQUIRING LOCAL SCHOOL BOARDS TO ADOPT POLICIES PERMITTING STUDENTS WITH ASTHMA OR STUDENTS SUBJECT TO ANAPHYLACTIC REACTIONS, OR BOTH, TO POSSESS AND SELF-ADMINISTER ASTHMA MEDICATION, AND TO RECODIFY CERTAIN STATUTES TO CREATE A NEW ARTICLE 26A IN CHAPTER 115C OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. Subchapter VI of Chapter 115C of the General Statutes is amended by adding the following new Article to read:

"Article 26A.

"Special Medical Needs of Students.

"**§ 115C-375.2. Possession and self-administration of asthma medication by students with asthma or students subject to anaphylactic reactions, or both.**

(a) Local boards of education shall adopt a policy authorizing a student with asthma or a student subject to anaphylactic reactions, or both, to possess and self-administer asthma medication on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events. As used in this section, "asthma medication" means a medicine prescribed for the treatment of asthma or anaphylactic reactions and includes a prescribed asthma inhaler or epinephrine auto-injector. The policy shall include a requirement that the student's parent or guardian provide to the school:

(1) Written authorization from the student's parent or guardian for the student to possess and self-administer asthma medication.

(2) A written statement from the student's health care practitioner verifying that the student has asthma or an allergy that could result in an anaphylactic reaction, or both, and that the health care practitioner prescribed medication for use on school property during the school

day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

(3) A written statement from the student's health care practitioner who prescribed the asthma medication that the student understands, has been instructed in self-administration of the asthma medication, and has demonstrated the skill level necessary to use the asthma medication and any device that is necessary to administer the asthma medication.

(4) A written treatment plan and written emergency protocol formulated by the health care practitioner who prescribed the medicine for managing the student's asthma or anaphylaxis episodes and for medication use by the student.

(5) A statement provided by the school and signed by the student's parent or guardian acknowledging that the local school administrative unit and its employees and agents are not liable for an injury arising from a student's possession and self-administration of asthma medication.

(6) Other requirements necessary to comply with State and federal laws.

(b) The student must demonstrate to the school nurse, or the nurse's designee, the skill level necessary to use the asthma medication and any device that is necessary to administer the medication.

(c) The student's parent or guardian shall provide to the school backup asthma medication that shall be kept at the student's school in a location to which the student has immediate access in the event of an asthma or anaphylaxis emergency.

(d) Information provided to the school by the student's parent or guardian shall be kept on file at the student's school in a location easily accessible in the event of an asthma or anaphylaxis emergency.

(e) If a student uses asthma medication prescribed for the student in a manner other than as prescribed, a school may impose on the student disciplinary action according to the school's disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the asthma medication.

(f) The requirement that permission granted for a student to possess and self-administer asthma medication shall be effective only for the same school and for 365 calendar days and must be renewed annually.

(g) No local board of education, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act authorized by this subsection, or for any omission relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 2.(a) G.S. 115C-307(c) reads as rewritten:

"(c) To Provide Some Medical Care to Students. – It is within the scope of duty of teachers, including substitute teachers, teacher assistants, student teachers or any other public school employee when given such authority by the board of education or its ~~designee, (i) to administer any drugs or medication prescribed by a doctor upon written request of the parents, (ii) to give emergency health care when reasonably apparent circumstances indicate that any delay would seriously worsen the physical condition or~~

~~endanger the life of the pupil, and (iii) to perform any other first aid or life saving techniques in which the employee has been trained in a program approved by the State Board of Education: Provided, that no one shall be required to administer drugs or medication or attend life saving techniques programs.~~

~~Any public school employee, authorized by the board of education or its designee to act under (i), (ii), or (iii) above, shall not be liable in civil damages for any such authorized act or for any omission relating to such act unless such act or omission amounts to gross negligence, wanton conduct or intentional wrongdoing. Any person, serving in a voluntary position at the request of or with the permission or consent of the board of education or its designee, who has been given the authority by the board of education or its designee to act under (ii) above shall not be liable in civil damages for any such authorized act or for any omission relating to such act unless the act amounts to gross negligence, wanton conduct or intentional wrongdoing.~~

~~At the commencement of each school year, but prior to the beginning of classes, and thereafter as circumstances require, the principal of each school shall determine which persons will participate in the medical care program.~~designee to provide medical care to students as provided in G.S. 115C-375.1."

SECTION 2.(b) Article 26A, as created in Section 1 of this act, is amended by adding the following new section to read:

"**§ 115C-375.1. To provide some medical care to students.**

It is within the scope of duty of teachers, including substitute teachers, teacher assistants, student teachers, or any other public school employee when authorized by the board of education or its designee, (i) to administer any drugs or medication prescribed by a doctor upon written request of the parents, (ii) to give emergency health care when reasonably apparent circumstances indicate that any delay would seriously worsen the physical condition or endanger the life of the pupil, and (iii) to perform any other first aid or lifesaving techniques in which the employee has been trained in a program approved by the State Board of Education. No employee, however, shall be required to administer drugs or medication or attend lifesaving techniques programs.

Any public school employee, authorized by the board of education or its designee to act under (i), (ii), or (iii) above, shall not be liable in civil damages for any authorized act or for any omission relating to that act unless the act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing. Any person, serving in a voluntary position at the request of or with the permission or consent of the board of education or its designee, who has been given the authority by the board of education or its designee to act under (ii) above shall not be liable in civil damages for any authorized act or for any omission relating to the act unless the act amounts to gross negligence, wanton conduct, or intentional wrongdoing.

At the commencement of each school year, but before the beginning of classes, and thereafter as circumstances require, the principal of each school shall determine which persons will participate in the medical care program."

SECTION 3.(a) G.S. 115C-47(42) is recodified as G.S. 115C-375.3.

SECTION 3.(b) G.S. 115C-375.3, as established in subsection (a) of this section, reads as rewritten:

"**§ 115C-375.3. ~~To Implement~~ Guidelines to support and assist students with diabetes.**

Local boards of education shall ensure that the guidelines adopted by the State Board of Education under G.S. 115C- 12(31) are implemented in schools in which students with diabetes are enrolled. In particular, the boards shall require the implementation of the procedures set forth in those guidelines for the development and implementation of individual diabetes care plans. Local boards also shall make available necessary information and staff development to teachers and school personnel in order to appropriately support and assist students with diabetes in accordance with their individual diabetes care plans."

SECTION 4.(a) G.S. 115C-47(44) is recodified as G.S. 115C-375.4.

SECTION 4.(b) G.S. 115C-375.4, as established in subsection (a) of this section, reads as rewritten:

"**§ 115C-375.4. ~~To Ensure that Schools Provide Information Concerning~~ Meningococcal Meningitis and Influenza and Their Vaccines.**

Local boards of education shall ensure that schools provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information shall include the causes, symptoms, and how meningococcal meningitis and influenza are spread and the places where parents and guardians may obtain additional information and vaccinations for their children."

SECTION 5. G.S. 115C-288(e) reads as rewritten:

"(e) To Discipline Students and to Assign Duties to Teachers with Regard to the Discipline, General Well-being, and Medical Care of Students. – The principal shall have authority to exercise discipline over the pupils of the school ~~pursuant to~~ under policies adopted by the local board of education as prescribed by G.S. 115C-391(a). The principal shall use reasonable force to discipline students ~~and shall assign duties to teachers with regard to the general well-being and the medical care of students pursuant to the provisions of G.S. 115C-307 and 115C-390. The principal also~~ under G.S. 115C-390 and may suspend or dismiss pupils ~~pursuant to the provisions of~~ under G.S. 115C-391. The principal shall assign duties to teachers with regard to the general well-being and the medical care of students under G.S. 115C-307 and Article 26A of this Chapter."

SECTION 6. The Department of Health and Human Services, Department of Public Instruction, or other appropriate State agencies shall apply for any federal grants for which the entity is eligible under 42 U.S.C. § 280g or other federal statutes or regulations related to treating, preventing, or training on children's asthma.

SECTION 7. This act is effective when it becomes law. G.S. 115C-375.2, as established in Section 1 of this act, applies beginning with the 2005-2006 school year.

HOUSE BILL 496:
Student Asthma Medications.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Reps. Harrison and Insko
Date:	April 20, 2005	**Summary by:**	Shawn Parker
Version:	Second Edition		Committee Staff

SUMMARY: ***House Bill 496 would require local boards of education to adopt policies that would allow students with asthma or subject to anaphylactic reactions, or both to possess and self-administer certain asthma or anaphylaxis medications. This bill also moves various statutes relating to the special medical needs of students into a new Article 26A of Chapter 115C. The bill takes effect when it becomes law and Section 1 of the act applies beginning with the 2005-06 school year.***

CURRENT LAW: Asthma is considered a disability under federal law. This means that public schools, including charter schools, cannot discriminate against a child with asthma. They also must provide reasonable accommodations so the child can participate in the school's programs and activities (including nonacademic programs and extracurricular activities). Each school system must designate an employee as its responsible employee for coordinating the system's efforts to comply with the federal laws (Section 504 of the Rehabilitation Act and the Americans with Disabilities Act). These individuals are commonly referred to as Section 504 representatives.

Parents can request that an individualized plan (known as a 504 Plan) be created to spell out the services that will be provided and the accommodations that will be made. These plans are done on a case-by-case basis, are intended to meet the specific needs of the child, and are re-evaluated on a regular basis (typically, every three years). What is necessary for one child may not be appropriate for another. If parents do not believe the school is providing appropriate services or accommodations, they have a right to appeal and may file a complaint with the federal Office of Civil Rights. The laws and regulations are silent on the details of what must specifically be provided to children with medical disabilities, including asthma.

BILL ANALYSIS:

Section 1 of the bill would require local boards of education to adopt policies allowing students with asthma, or subject to anaphylactic reactions, or both to possess and self-administer their asthma medication. "Asthma medication" is defined as medicine prescribed for the treatment of asthma or anaphylactic reactions, including an asthma inhaler and epinephrine auto-injector. Parents or guardians will be required to provide the school certain documentation including:

Written authorization from the parent or guardian for the student to self-administer asthma medication

A written statement from the student's health care practitioner verifying that the student has asthma, that medicine was prescribed for the student's use and that the student has demonstrated the ability to self-administer the medication

A written treatment plan and emergency protocol developed by the health care practitioner

A statement signed by the parent or guardian that acknowledges that the local school system and its employees are not liable for an injury arising from the student possessing and self-administering asthma medication

The authorization to possess and self-administer asthma medications is for 365 calendar days and covers the student while on school property during the school day, during school-sponsored activities or during transit to and from school-sponsored events. The authorization must be renewed annually.

The school may impose disciplinary action on the student if the student does not use the medicine as prescribed but may not restrict the student's immediate access to their medication. The student's parent or guardian must provide backup medication that must be kept in a location immediately accessible to a student in case of an emergency.

Sections 2 through 5 of the bill recodify existing statutes related to the special medical needs of students into the new Article 26A of Chapter 115C.

Section 6 of the bill directs the Department of Health and Human Services, Department of Public Instruction or other appropriate agency to apply for federal grants relating to treating, preventing or training about children's asthma.

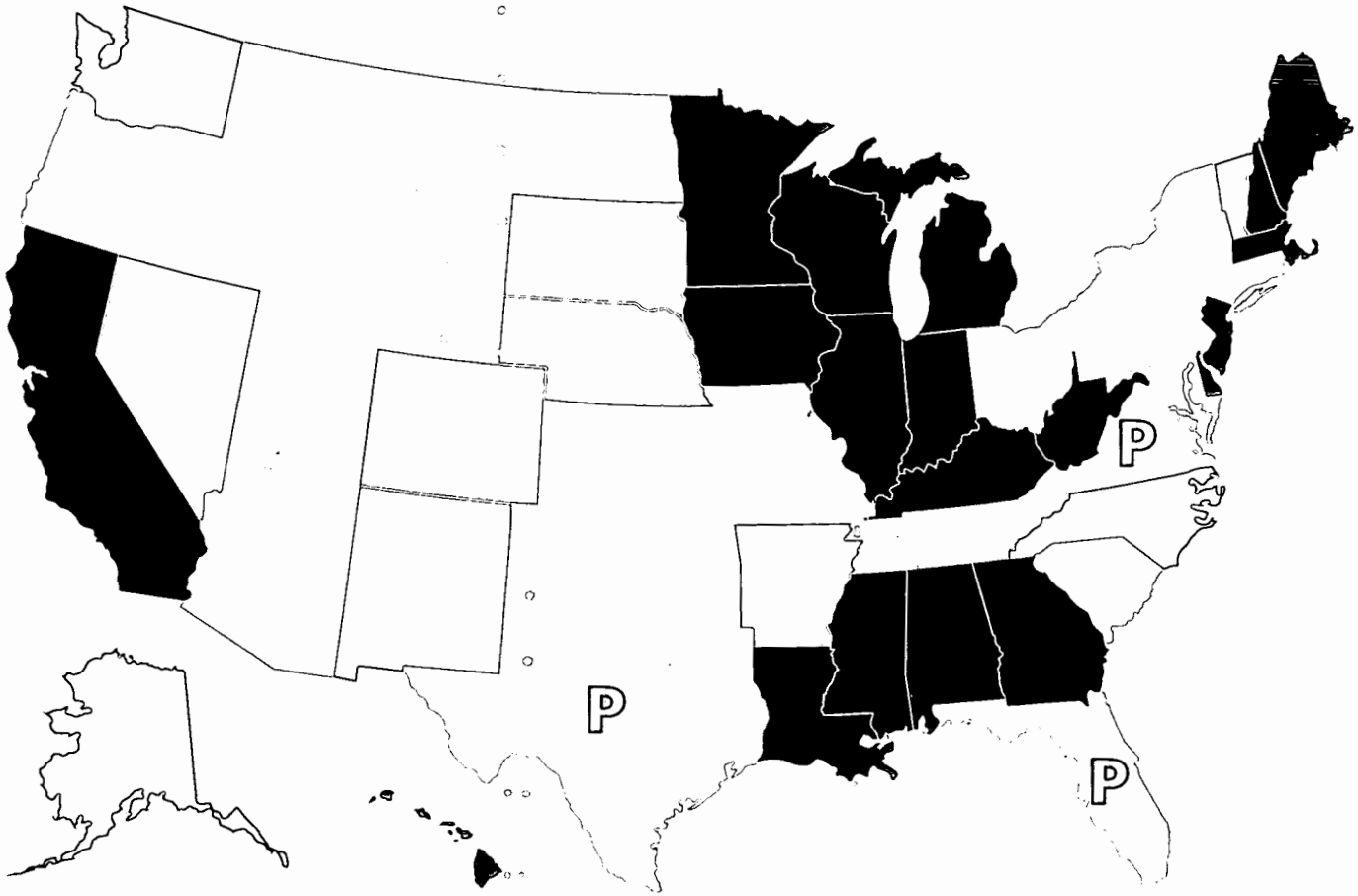
BACKGROUND: According to information from the National Conference for State Legislatures (NCSL), 14 states have laws or rules that allow students to carry and self-administer prescribed medication for asthma and anaphylaxis. 16 states have laws that allow students to only carry and administer prescribed medication for asthma. 20 states have no law, rule or regulation allowing students to carry and self-administer prescribed medication for both asthma and anaphylaxis or just medication for asthma. Last year, Congress passed the "Asthmatic Schoolchildren's Treatment and Health Management Act of 2004" that gives a state preference for receiving federal grants related to asthma if the state allows students to self-administer medication for asthma and anaphylaxis.

Legislative Analyst Sara Kamprath contributed to this Summary.

H496-SMSQ-001

Allergy & Asthma Network
Mothers of Asthmatics

State Statutes Protecting Student Rights to Carry and Use Prescribed Asthma and Anaphylaxis Medications



Color Key:

- ■ States that protect student rights to possess and self-administer prescribed lifesaving asthma and anaphylaxis medications.
- ☐ States that protect student rights to possess and self-administer prescribed lifesaving asthma medications.
- [P] States that protect student rights to possess and self-administer prescribed lifesaving asthma medications and have pending legislation also allowing anaplylaxis medications.
- ☐ States that have pending legislation.
- ☐ States that do not have statutes protecting student rights to possess and self-administer prescribed lifesaving asthma and/or anaphylaxis medications.

Updates at 800.878.4403 *breatherville.org*

AANMA01/2004-0162-PDF

31 states

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 326
PROPOSED COMMITTEE SUBSTITUTE S326-PCS75293-SW-22

Short Title: Retired Nurses Return to Work. (Public)

Sponsors:

Referred to:

March 3, 2005

A BILL TO BE ENTITLED

AN ACT TO ENABLE RETIRED REGISTERED NURSES TO RETURN TO EMPLOYMENT TEACHING AT COMMUNITY COLLEGES WITHOUT LOSING RETIREMENT BENEFITS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-3(8)c. reads as rewritten:

"c. Should a beneficiary who retired on an early or service retirement allowance under this Chapter be reemployed, or otherwise engaged to perform services, by an employer participating in the Retirement System on a part-time, temporary, interim, or on a fee-for-service basis, whether contractual or otherwise, and if such beneficiary earns an amount during the 12-month period immediately following the effective date of retirement or in any calendar year which exceeds fifty percent (50%) of the reported compensation, excluding terminal payments, during the 12 months of service preceding the effective date of retirement, or twenty thousand dollars ($20,000), whichever is greater, as hereinafter indexed, then the retirement allowance shall be suspended as of the first day of the month following the month in which the reemployment earnings exceed the amount above, for the balance of the calendar year. The retirement allowance of the beneficiary shall be reinstated as of January 1 of each year following suspension. The amount that may be earned before suspension shall be increased on January 1 of each year by the ratio of the Consumer Price Index to the Index one year earlier, calculated to the nearest tenth of a percent (1/10 of 1%).

The computation of postretirement earnings of a beneficiary under this sub-subdivision, G.S. 135-3(8)c., who has been retired at least six months and has not been employed in any capacity, except as a substitute teacher or a part-time tutor, with a public school for at least six months immediately preceding the effective date of reemployment, shall not include earnings while the beneficiary is employed to teach on a substitute, interim, or permanent basis in a public school. The Department of Public Instruction shall certify to the Retirement System that a beneficiary is employed to teach by a local school administrative unit under the provisions of this sub-subdivision and as a retired teacher as the term is defined under the provisions of G.S. 115C-325(a)(5a).

The computation of postretirement earnings of a beneficiary under this sub-subdivision who is a registered nurse with a masters degree in nursing and who has been retired at least six months and has not been employed in any capacity by the State for at least six months immediately preceding the effective date of reemployment, shall not include earnings while the beneficiary is employed to teach nursing at a community college or a constituent institution of The University of North Carolina. The Department of Community Colleges or the Board of Governors of The University of North Carolina, as applicable, shall certify to the Retirement System that a beneficiary is employed to teach by a community college or constituent institution of The University of North Carolina under the provisions of this sub-subdivision and as a retired registered nurse.

Beneficiaries employed under this sub-subdivision are not entitled to any benefits otherwise provided under this Chapter as a result of this period of employment."

SECTION 2. This act becomes effective July 1, 2005.

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 20, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	AstraZeneca
Barbara Carsley	BSCGL
Lin Coppedge MD	Duke Day
Sandra A. Brown	Nurse of the Day
Cindy Moseley	5319 Coverview Ct, Greensboro 27407
Katherine Joyce	NCASA
Christine Craig	Wakemed
Molly Ryan	NCSBA
John Cyrus	NCSG
[illegible]	Bom : Asso.
Rex Smith	NCMA

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 20, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kyle Pruitt	ESMS
Cody Johnson	ESHS
Marcus Martin	ESHS
Jaya Craig	ESHS
Lucas Fowler	ESHS
Caitlin Lamb	East Surry High School
Nicole Harris	East Surry High School
Rodney E. Hall	Log Association
Pam Dearadorff	Retirement
Tom Vitaglione	NCLAI
Barbara Holt	NCRLA

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 20, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charlene Carey	Elon University

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 20, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alex S. Lunson	Nurse Anesthesia WFUBMC - W.S. North Carolina
Clifford Gonzales	Nurse Anesthesia WFUBMC - W. S. N. C.
Amanda Lassiter	Nurse Anesthesia Program Wake Forest Univ. Baptist Med. Ctr. W/S, NC
Andra Haverly	Nurse Anesthesia Program WFUBMC W.S. - NC
Mimi Antonecchia	ESHS
Meghan Shelton	ESHS
Jessica Cooke	East Surry High School
Marcus Dunn	NCAE
Maggie Lawson	East Surry High School
Heather Vogler	east surry high school
Ashley Ayers	ESHS

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **April 20, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Linda Johns	Warren Co Home Health / Health Dept Warrenton
Leann Whitley	NCSBA
	WCPSS
Cam Cass	BOMLL
DAVID BARNES	Poyner + Spruill

AGENDA

SENATE HEALTH CARE COMMITTEE
April 27, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered:

- SB 208, Amend Occupational Therapy Laws/Fees
- HB 707, Amend Star-Rated Licensure/Child Care Fac.-AB
- SB 1059, Perfusionists Licensure

III. Other Business

IV. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, April 27, 2005

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

FAVORABLE

H.B. **707** Amend Star-Rated Licensure/Child Care Fac.-AB
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chairman
Senator Stan Bingham, Co-Chairman

Tuesday, May 3, 2005

Senator Purcell,
submits the following with recommendations as to passage:

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

S.B. **208** Amend Occupational Therapy Laws/Fees.

Draft Number:	PCS55218
Sequential Referral:	None
Recommended Referral:	No
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, April 27, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 27, 2005, in Room 544 of the Legislative Office Building, with twelve members present. Senator William R. Purcell, Co-Chair, presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. .

Senator Purcell introduced Senator Lucas to present a proposed committee substitute for SB 208, *Amend Occupational Therapy Laws/Fees* to the Committee. She said that this bill would update the Occupational Therapy Licensure Act to reflect changes that have occurred since its inception in 1984, and that it does not expand its scope, does not raise fees, but does raise the ceiling on fees. Senator Forrester questioned whether the scope of practice is increased under this bill. Sen. Lucas called on Evelyn Hawthorne, representing the Occupational Therapy Association. Ms. Hawthorne introduced people from this organization, including Bill Walsh of the Hand Therapy Association, to answer Sen. Forrester's question. Mr. Walsh pointed out that the hand therapists have been managing many different types of hand wounds, such as severe burns, and that such care has been routine practice for occupational therapy. Sen. Bingham asked about "modification of environments". Carol Siebert, President-Elect of the Occupational Therapy Association, said that occupational therapists will work with architects when persons sustain disabilities requiring modification of a home environment. Senator Dannelly questioned late fees being added to renewal fees, and staff responded that the two fees are be required. Brenda Kennell, Chairperson of the N. C. Board of Occupational Therapy, responded that the two fees are $50 each, and there are no plans at this time to raise each fee to $100. William Potter, representing the N. C. Physical Therapy Association, said that various actions listed in the bill, as well as use of various properties would allow occupational therapists to work without the direct supervision of a physician. He said that the curriculum for occupational therapists does not include training in these various actions and the use of these various properties, as well as in manual therapy. He requested permission to introduce Dr. Darlene Sekerak, Director of the Physical Therapy Dept. at UNC-Chapel Hill. She reiterated the concerns expressed by Mr. Potter. Sen. Forrester asked Sen. Lucas if she would consider removing Section 12, page 3 from the bill. The answer was "no" and Sen. Forrester said that he would not support the bill because of that. Sen. Kinnaird asked if the curriculum covered the actions listed in Section 12. Ms. Kennall responded that the occupational therapy curriculum does cover these hands-on techniques. Mr. Potter disputed that. Mr. Dan Dore, President of the N.C. Physical Therapy Association, agreed with Mr. Potter. Sen. Lucas moved for a favorable report, the bill passed, and was referred to Finance.

Rep. Martha Alexander was recognized to present HB 707, *Amend Star-Rated Licensure/Child Care Fac.-AB*. She said that this bill would allow quality child care to be addressed in a much better manner. Sen. Dorsett asked about licensure standards. Roz Savitt, representing the N.C. Child Care Coalition, spoke in favor of the bill. Sen. Dannelly moved for a favorable report. The bill passed.

SB 1059, *Perfusionists Licensure*, was postponed until the next meeting due to lack of time to discuss the bill.

The meeting adjourned at 11:50 A.M.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Lorraine R. Blake, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 208*

Short Title:	Amend Occupational Therapy Laws/Fees.	(Public)
Sponsors:	Senator Lucas.	
Referred to:	Health Care.	

February 24, 2005

A BILL TO BE ENTITLED

AN ACT AMENDING CERTAIN LAWS RELATING TO THE NORTH CAROLINA OCCUPATIONAL THERAPY PRACTICE ACT AND AUTHORIZING THE NORTH CAROLINA BOARD OF OCCUPATIONAL THERAPY TO RAISE THE CEILING ON ITS FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.66 reads as rewritten:

"**§ 90-270.66. Declaration of purpose.**

The North Carolina Occupational Therapy Practice Act is enacted to safeguard the public health, safety and welfare, to protect the public from being harmed by unqualified persons, to assure the highest degree of professional ~~care~~ services and conduct on the part of occupational therapists and occupational ~~therapist~~ therapy assistants, to provide for the establishment of ~~standards of education,~~licensure requirements, and to insure the availability of occupational therapy services of high quality to persons in need of such services. It is the purpose of this Article to provide for the regulation of persons offering occupational therapy services to the public."

SECTION 2. G.S. 90-270.67 reads as rewritten:

"**§ 90-270.67. Definitions.**

As used in this Article, unless the context clearly requires a different meaning:

(1) Accrediting body. – The Accrediting Council for Occupational Therapy Education.

~~(1)~~(1a) ~~"Board" means the~~Board. – The North Carolina Board of Occupational Therapy.

(1b) Examining body. – The National Board for Certification in Occupational Therapy.

(2) ~~"Occupational therapist" means an~~Occupational therapist. – An individual licensed in good standing to practice occupational therapy as defined in this Article.

(3) ~~"Occupational therapist assistant" means an~~Occupational therapy assistant. – An individual licensed in good standing to assist in the practice of occupational therapy under this Article, who performs activities commensurate with his or her education and training under the supervision of a licensed occupational therapist.

(4) ~~"Occupational therapy" means a health care profession providing evaluation, treatment and consultation to help individuals achieve a maximum level of independence by developing skills and abilities interfered with by disease, emotional disorder, physical injury, the aging process, or impaired development. Occupational therapists use purposeful activities and specially designed orthotic and prosthetic devices to reduce specific impairments and to help individuals achieve independence at home and in the work place.~~

Occupational therapy. – The therapeutic use of everyday life activities with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, or other settings.

(5) ~~"Person" means any~~Person. – Any individual, partnership, unincorporated organization, or corporate body, except that only an individual may be licensed under this Article."

SECTION 3. Article 18D of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-270.67A. Practice of occupational therapy.**

Occupational therapy services are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychological, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life. The practice of occupational therapy includes:

(a) Various methods that shall include the following:

(1) Establishment, remediation, or restoration of a skill that has not yet developed or is impaired.

(2) Compensation, modification, or adaptation of activity or environment to enhance performance.

(3) Maintenance and enhancement of capabilities without which performance in everyday life activities would decline.

(4) Health and wellness promotion to enable or enhance performance in everyday life activities.

(5) Prevention of barriers to performance, including disability prevention.

(b) Evaluation of factors affecting activities of daily living 'ADL', instrumental activities of daily living 'IADL', education, work, play, leisure, and social participation including:

(1) Client factors, including physiological and anatomical systems.

(2) Habits, routines, roles, and behavior patterns.

(3) Cultural, physical, environmental, social and spiritual contexts, and activity demands that affect performance.

(4) Performance skills, including motor, process, and interaction skills.

(c) Interventions and procedures to promote or enhance safety and performance in activities of daily living 'ADL', instrumental activities of daily living 'IADL', education, work, play, leisure, and social participation including:

(1) Therapeutic use of occupations, exercises, and activities.

(2) Training in self-care, self-management, home management, and community or work reintegration.

(3) Development, remediation, or compensation of physical, cognitive, neuromuscular, and behavioral skills.

(4) Therapeutic use of self, including the client's personality, insights, perceptions, and judgments as part of the therapeutic process.

(5) Education and training of individuals, including family members, caregivers, and others.

(6) Care coordination, case management, and transition services.

(7) Consultative services to groups, programs, organizations, or communities.

(8) Modification of environments, including home, work, school, or community and adaptation of processes, including the application of ergonomic principles.

(9) Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices and training in the use of prosthetic devices.

(10) Assessment, recommendation, and training in techniques to enhance mobility, including wheelchair management and adaptive driving.

(11) Management of feeding, eating, and swallowing to enable eating and feeding performance.

(12) Application of physical agent modalities and use of a range of specific therapeutic procedures, including wound care management, techniques to enhance sensory, perceptual, and cognitive processing, and manual therapy techniques to enhance performance skills."

SECTION 4. G.S. 90-270.68 reads as rewritten:

"**§ 90-270.68. Establishment of Board, ~~terms of members,~~terms, vacancies, removal, meetings, compensation.**

(a) Establishment of Board. – The North Carolina Board of Occupational Therapy is created. The Board shall ~~have six members. All members shall be~~consist of seven members who are appointed by the Governor and ~~shall be~~are residents of this State at the time of and during their ~~appointment.~~appointment, as follows:

(1) Three members shall be occupational therapists and one member shall be an occupational ~~therapist assistant; each~~therapy assistant. Each of these members shall be licensed to practice in North Carolina and have practiced, taught, or engaged in research in occupational therapy for at

least three of the five years immediately preceding appointment to the Board.

(2) ~~The fifth board~~One member shall be a physician in good standing with the North Carolina Medical Board and licensed by and registered with the North Carolina Medical Board to practice ~~medicine; and~~medicine in this State.

(3) ~~the sixth board~~One member shall represent the public at large and shall be a person who is not a health care provider licensed under this ~~Chapter.~~Chapter or the spouse of a licensed health care provider.

(4) One member shall be a counselor, educator, or school-based professional certified or licensed under North Carolina law who is employed in the North Carolina Public School System and is not an occupational therapist or an occupational therapy assistant.

The ~~medical doctor, occupational therapists, and occupational therapist assistant~~occupational therapist members and the occupational therapy assistant member shall be ~~appointed by the Governor from a list compiled~~nominated by the North Carolina Occupational Therapy Association, Inc., following the use of a ~~nomination~~ procedure made available to all occupational therapists and occupational ~~therapist~~ therapy assistants licensed and residing in North Carolina. In soliciting nominations and compiling its list, the Association shall give consideration to geographic distribution, clinical specialty, and other factors that will promote representation of all aspects of occupational therapy practice. The records of the nomination procedures shall be filed with the Board and made available for a period of six months following nomination for reasonable inspection by any licensed practitioner of occupational therapy.

The physician member shall be nominated by the North Carolina Occupational Therapy Association, Inc., after consultation with the North Carolina Medical Society. The counselor, educator, or school-based professional member shall be nominated by the North Carolina Occupational Therapy Association, Inc., after consultation with the North Carolina School Counselor's Association.

(b) Terms. – Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive four-year terms, unless a member is appointed to fill a vacancy for an unexpired term, then that member may complete the unexpired term and serve one additional four-year term.

(c) Vacancies. – In the event ~~that~~ a member of the Board cannot complete a term of office, the vacancy shall be filled by appointment by the Governor, in accordance with the procedures set forth in this section, for the remainder of the unexpired term.

(d) 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 participating in Board business until the charges are resolved.

(e) Meetings. – Each year the Board shall meet and designate a ~~chairman~~ chairperson, a vice-chairperson, and a secretary-treasurer from among its members. The Board may hold additional meetings upon call of the ~~chairman~~ chairperson or any two board members. A majority of the Board membership shall constitute a quorum.

(f) Compensation. – Members of the Board shall receive no compensation for their services, but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5."

SECTION 5. G.S. 90-270.69 reads as rewritten:

"**§ 90-270.69. Powers and duties of the Board.**

The Board shall have the following powers and duties:

(1) ~~Examine~~ Establish and determine the qualifications and fitness of applicants for licensure to practice occupational therapy in this ~~State;~~State.

(2) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this ~~Article;~~Article.

(2a) Communicate disciplinary actions to relevant State and federal authorities and to other state occupational therapy licensing authorities.

(3) Issue and renew, and deny, suspend, revoke or refuse to issue or renew any license under this ~~Article;~~Article.

(4) Adopt, amend, or repeal any reasonable rules or regulations necessary to carry out the purposes of this Article, including but not limited to rules establishing ethical standards of ~~practice;~~practice.

(5) Employ professional, clerical, investigative or special personnel necessary to carry out the provisions of this Article, and purchase or rent office space, equipment and ~~supplies;~~supplies.

(6) Adopt a seal by which it shall authenticate its proceedings, official records, and ~~licenses;~~licenses.

(7) Conduct administrative hearings in accordance with Chapter 150B of the General Statutes when a "contested case" as defined in G.S. 150B-2(2) arises under this ~~Article;~~Article.

(8) Establish reasonable fees for applications for ~~examination; initial, provisional,~~initial limited permits and renewal ~~licenses;~~licenses and other services provided by the ~~Board;~~Board.

(9) Submit an annual report to the Governor and General Assembly of all its official actions during the preceding year, together with any recommendations and findings regarding improvement of the profession of occupational ~~therapy;~~therapy.

(10) Publish and make available upon request the licensure standards prescribed under this Article and all rules and regulations established by the ~~Board;~~Board.

(11) ~~Approve educational curricula and field work experience accredited by the American Medical Association and American Occupational Therapy Association for persons seeking licensure under this Article.~~Conduct a training program as needed for new board members designed to familiarize new members with their duties."

SECTION 6. G.S. 90-270.70 reads as rewritten:

"**§ 90-270.70. Requirements for licensure.**

(a) Any individual who desires to be licensed as an occupational therapist or occupational ~~therapist~~ therapy assistant shall file a written application with the Board on forms provided by the Board, showing to the satisfaction of the Board that the applicant:

(1) Is of good moral character; and

(2) Has passed an examination approved by the Board as provided in this Article.

Applicants for licensure as an occupational therapist must also have successfully completed an accredited occupational therapy educational curriculum and the required supervised ~~field work experience of at least six months' duration.~~fieldwork as determined by the Board. Applicants for licensure as an occupational ~~therapist~~ therapy assistant must also have successfully completed an accredited occupational therapy assistant educational curriculum and the required supervised ~~field work experience of at least two months' duration.~~fieldwork as determined by the Board.

(b) Occupational therapists who are trained outside of the United States and its territories shall satisfy the examination and educational requirements as stated in subsection (a) of this section. The Board shall require these applicants to meet examination eligibility requirements as established by the credentialing body recognized by the Board before taking the examination."

SECTION 7. G.S. 90-270.71 is repealed.

SECTION 8. G.S. 90-270.72 reads as rewritten:

"**§ 90-270.72. Exemption from requirements.**

~~(a) The Board shall waive the examination, education, and field work requirements of G.S. 90-270.70 and shall grant a license to any applicant who presents evidence satisfactory to the Board that he or she has been engaged in the practice of occupational therapy as an occupational therapist or occupational therapist assistant before September 1, 1984. Proof of such actual practice shall be presented to the Board as established by regulation. To qualify for exemption under this section, the applicant shall file an application for licensure no later than September 1, 1985.~~

~~(b)~~ The Board may ~~grant a license without examination to any applicant who~~ exempt an applicant from certain licensure requirements if the applicant presents proof satisfactory to the Board of current licensure as an occupational therapist or occupational ~~therapist~~ therapy assistant in another state or the District of Columbia, Puerto Rico, or Guam, provided the other jurisdiction's licensure standards are considered by the Board to be substantially equivalent to or higher than those prescribed in this Article."

SECTION 9. G.S. 90-270.73 reads as rewritten:

"**§ 90-270.73. Issuance of license.**

(a) The Board shall issue a license to any individual who meets the requirements of this Article upon payment of the license fee prescribed in G.S. 90-270.77.

(b) Any individual licensed as an occupational therapist under this Article may use the words "occupational therapist" and may use the letters "O.T." or ~~"O.T.R./L."~~'O.T./L.' in connection with his name or place of business.

(c) Any individual licensed as an occupational ~~therapist~~ therapy assistant under this Article may use the words "occupational ~~therapist~~ therapy assistant" and may use

the ~~letter~~ letters "O.T.A." or ~~"C.O.T.A./L."~~'O.T.A./L.' in connection with his name or place of business.

(d) Any individual possessing a limited permit to practice occupational therapy may use the words 'occupational therapy limited permittee' or 'occupational therapy assistant limited permittee' and may use the letters 'O.T./L.P.' or 'O.T.A./L.P.' in connection with his or her name or place of business."

SECTION 10. G.S. 90-270.74 reads as rewritten:

"**§ 90-270.74. ~~Provisional licenses.~~Limited permits.**

The Board may grant a ~~provisional license for a period not exceeding nine months to any~~limited permit to an individual who has successfully completed the educational and field work ~~experience~~ requirements ~~and has made application to take the examination~~ for examination but has not yet taken or received the results of the examination required under G.S. 90-270.70. A ~~provisional license~~limited permit shall be valid for 120 days and shall allow the individual to practice as an occupational therapist or occupational ~~therapist~~ therapy assistant under the supervision of an occupational therapist licensed in this ~~State and shall be valid until revoked by the Board. A provisional license~~State. A limited permit shall expire when the individual is issued a license under G.S. 90-270.73 or if the individual is notified that he or she did not pass the examination. A limited permit is not renewable. A limited permit shall not be issued to an applicant who has failed the ~~examination in this State or another jurisdiction.~~examination."

SECTION 11. G.S. 90-270.75(a) reads as rewritten:

"(a) Licenses issued under this Article shall be subject to annual renewal upon completion of ~~such~~ continuing education and competency requirements as may be required by the Board, upon the payment of a renewal fee specified under G.S. 90-270.77 and in compliance with this Article, and shall expire unless renewed in the manner prescribed by the Board. The Board may provide for the late renewal of a license upon the payment of a late fee in accordance with G.S. 90-270.77, but no such late renewal may be granted more than five years after a license expires."

SECTION 12. G.S. 90-270.76 reads as rewritten:

"**§ 90-270.76. Suspension, revocation and refusal to renew license.**

(a) The Board may deny or refuse to renew a license, may suspend or revoke a license, or may impose probationary conditions on a license if the licensee or applicant for licensure has engaged in any of the following conduct:

(1) ~~Employment of fraud, deceit or misrepresentation in obtaining or attempting to obtain a license, or the renewal thereof;~~Obtaining a license by means of fraud, misrepresentation, or concealment of material facts.

(2) ~~Conviction of or a plea of guilty or nolo contendere to any crime involving moral turpitude;~~Engaging in unprofessional conduct pursuant to rules established by the Board or violating the Code of Ethics adopted and published by the Board.

(3) ~~Adjudication of insanity or incompetency, until proof of recovery from the condition can be established;~~Having been convicted of or pleaded

guilty or nolo contendere to a crime involving moral turpitude or any crime which indicates that the occupational therapist or occupational therapy assistant is unfit or incompetent to practice occupational therapy or that the occupational therapist or occupational therapy assistant has deceived or defrauded the public.

(4) Engaging in any act or practice violative of any of the provisions of this Article or any rule or regulation adopted by the Board ~~hereunder,~~ or aiding, abetting or assisting any person in such a ~~violation;~~violation.

(5) Committing an act or acts of malpractice, gross negligence or incompetence in the practice of occupational ~~therapy;~~therapy.

(6) Practicing as a licensed occupational therapist or occupational therapist assistant without a current ~~license;~~license.

(7) Engaging in conduct that could result in harm or injury to the public.

(8) Having an occupational therapy license revoked or suspended or other disciplinary action taken whether in this State or another jurisdiction.

(9) Being unfit or incompetent to practice occupational therapy by reason of deliberate or negligent acts or omissions regardless of whether actual injury to a patient is established.

(b) ~~Such~~ The denial, refusal to renew, suspension, revocation or imposition of probationary conditions upon a license may be ordered by the Board after a hearing held in accordance with G.S. Chapter 150B and rules adopted by the Board. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year."

SECTION 13. G.S. 90-270.77 reads as rewritten:

"**§ 90-270.77. Fees.**

The Board shall adopt and publish, in the manner established by its rules and regulations, fees reasonably necessary to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed ~~ten dollars ($10.00);~~twenty-five dollars ($25.00).

(2) For ~~examination, reexamination, or~~ issuance of ~~a license~~ an initial license, a fee not to exceed ~~one hundred dollars ($100.00);~~two hundred dollars ($200.00).

(3) For the renewal of a license, a fee not to exceed ~~fifty dollars ($50.00);~~one hundred dollars ($100.00).

(4) For the late renewal of a license, a fee not to exceed ~~fifty dollars ($50.00);~~one hundred dollars ($100.00).

(5) For a ~~provisional license;~~limited permit, a fee not to exceed ~~thirty-five dollars ($35.00); and~~fifty dollars ($50.00).

(6) For copies of Board rules and licensure standards, charges not ~~exceeding~~ to exceed the actual cost of printing and mailing."

SECTION 14. G.S. 90-270.78 reads as rewritten:

"**§ 90-270.78. False representation of license prohibited.**

(a) It is unlawful for any person who is not licensed in accordance with this Article or whose license has been suspended, revoked or not renewed by the Board to:

(1) Engage in the practice of occupational ~~therapy;~~therapy.

(2) Orally, in writing, in print or by sign, or in any other manner, directly or by implication, represent that he or she is engaging in occupational ~~therapy; or~~therapy.

(3) Use in connection with his or her name or place of business the words ~~"occupational therapist" or "occupational therapist assistant";~~'occupational therapist', 'occupational therapy assistant', 'occupational therapist limited permittee', or 'occupational therapy assistant limited permittee', or the letters "O.T.", ~~"O.T.R./L.",~~'O.T./L.', "O.T.A.", ~~or "C.O.T.A./L."~~'O.T.A./L.', 'O.T./L.P.', or 'O.T.A./L.P.' or any other words, letters, abbreviations or insignia indicating or implying that the person is an occupational ~~therapist or~~therapist, occupational ~~therapist assistant.~~therapy assistant, occupational therapist limited permittee, or occupational therapy assistant limited permittee.

(b) Any person who resides in another state or foreign country and who, by use of electronic or other medium, performs any of the acts described as the practice of occupational therapy pursuant to this Article, but is not licensed pursuant to this Article, shall be regarded as practicing occupational therapy without a North Carolina license and is subject to the provisions of this Article and appropriate regulation by the Board."

SECTION 15. Article 18D of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-270.80A. Civil penalties, disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Board may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of 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, the Board shall 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 and rules adopted by the Board.

(d) Costs. – The Board may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Board."

SECTION 16. G.S. 90-270.81 reads as rewritten:

"**§ 90-270.81. Persons and practices not affected.**

Nothing in this Article shall be construed to prevent or restrict:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State from performing work incidental to the practice of that profession or occupation as long as the person does not represent himself or herself as an occupational therapist or occupational ~~therapist assistant;~~therapy assistant.

(2) Any person employed as an occupational therapist or occupational ~~therapist~~ therapy assistant by the government of the United States, if he or she provides occupational therapy solely under the direction or control of the organization by which he or she is ~~employed;~~employed.

(3) Any person pursuing a course of study leading to a degree or certificate in occupational therapy at an accredited or approved educational program if ~~such~~ the activities and services constitute a part of a supervised course of study and if the person is designated by a title which clearly indicates his or her status as a student or ~~trainee;~~trainee.

(4) Any person fulfilling the supervised ~~field work~~fieldwork experience required for licensure under this Article if the person is designated by a ~~title which~~title, which clearly indicates his or her status as a student or ~~trainee;~~trainee.

(5) Occupational therapists or occupational ~~therapist~~ therapy assistants licensed in other jurisdictions who are ~~teaching~~ consulting, teaching, or participating in special occupational therapy education projects, demonstrations or courses in this State, provided their evaluation and treatment of patients is minimal.

(6) The practice of occupational therapy by an occupational therapist or occupational therapy assistant licensed in another jurisdiction who comes into this State, whether in person or by use of any electronic or other medium, on an irregular basis, to consult with a North Carolina licensed occupational therapist or occupational therapy assistant or to consult with faculty at an academic facility about education and training. This shall not apply to occupational therapists or occupational therapy assistants residing in a neighboring state and regularly practicing in this State."

SECTION 17. All members serving on the North Carolina Board of Occupational Therapy on the effective date of this act shall complete their current terms. Upon completion of their current terms, the occupational therapists members, the occupational therapy assistant member, and the physician member shall be eligible to serve one additional four-year term. The Governor shall appoint a new public member to serve a four-year term. The Governor shall also appoint the counselor, educator, or school-based professional member for a four-year term pursuant to

G.S. 90-270.68(a)(4), as enacted in Section 4 of this act, to begin October 1, 2005. Members appointed thereafter shall serve four-year terms.

SECTION 18. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 208*
PROPOSED COMMITTEE SUBSTITUTE S208-CSSQ-5 [v.5]

4/25/2005 11:45:30 AM

Short Title: Amend Occupational Therapy Laws/Fees. (Public)

Sponsors:

Referred to:

February 24, 2005

A BILL TO BE ENTITLED

AN ACT AMENDING CERTAIN LAWS RELATING TO THE NORTH CAROLINA OCCUPATIONAL THERAPY PRACTICE ACT AND AUTHORIZING THE NORTH CAROLINA BOARD OF OCCUPATIONAL THERAPY TO RAISE THE CEILING ON ITS FEES.

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~~(1)~~(1a) ~~"Board" means the~~Board. – The North Carolina Board of Occupational Therapy.

(1b) Examining body. – The National Board for Certification in Occupational Therapy.

(2) ~~"Occupational therapist" means an~~Occupational therapist. – An individual licensed in good standing to practice occupational therapy as defined in this Article.

(3) ~~"Occupational therapist assistant" means an~~Occupational therapy assistant. – An individual licensed in good standing to assist in the practice of occupational therapy under this Article, who performs activities commensurate with his or her education and training under the supervision of a licensed occupational therapist.

(4) ~~"Occupational therapy" means a health care profession providing evaluation, treatment and consultation to help individuals achieve a maximum level of independence by developing skills and abilities interfered with by disease, emotional disorder, physical injury, the aging process, or impaired development. Occupational therapists use purposeful activities and specially designed orthotic and prosthetic devices to reduce specific impairments and to help individuals achieve independence at home and in the work place.~~

Occupational therapy. – The therapeutic use of everyday life activities with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, or other settings.

(5) ~~"Person" means any~~Person. – Any individual, partnership, unincorporated organization, or corporate body, except that only an individual may be licensed under this Article."

SECTION 3. Article 18D of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-270.67A. Practice of occupational therapy.**

Occupational therapy services are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life. The practice of occupational therapy includes:

(a) Various methods that shall include the following:

(1) Establishment, remediation, or restoration of a skill that has not yet developed or is impaired.

(2) Compensation, modification, or adaptation of activity or environment to enhance performance.

(3) Maintenance and enhancement of capabilities without which performance in everyday life activities would decline.

(4) Health and wellness promotion to enable or enhance performance in everyday life activities.

(5) Prevention of barriers to performance, including disability prevention.

(b) Evaluation of factors affecting activities of daily living 'ADL', instrumental activities of daily living 'IADL', education, work, play, leisure, and social participation including:

(1) Client factors, including physiological and anatomical systems.

(2) Habits, routines, roles, and behavior patterns.

(3) Cultural, physical, environmental, social and spiritual contexts, and activity demands that affect performance.

(4) Performance skills, including motor, process, and interaction skills.

(c) Interventions and procedures to promote or enhance safety and performance in activities of daily living 'ADL', instrumental activities of daily living 'IADL', education, work, play, leisure, and social participation including:

(1) Therapeutic use of occupations, exercises, and activities.

(2) Training in self-care, self-management, home management, and community or work reintegration.

(3) Development, remediation, or compensation of physical, cognitive, neuromuscular, and behavioral skills.

(4) Therapeutic use of self, including the client's personality, insights, perceptions, and judgments as part of the therapeutic process.

(5) Education and training of individuals, including family members, caregivers, and others.

(6) Care coordination, case management, and transition services.

(7) Consultative services to groups, programs, organizations, or communities.

(8) Modification of environments, including home, work, school, or community and adaptation of processes, including the application of ergonomic principles.

(9) Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices and training in the use of prosthetic devices.

(10) Assessment, recommendation, and training in techniques to enhance mobility, including wheelchair management and adaptive driving.

(11) Management of feeding, eating, and swallowing to enable eating and feeding performance.

(12) Enhancement of performance skills by application of physical agent modalities and use of a range of specific therapeutic procedures, including wound care management; techniques to enhance sensory, perceptual, and cognitive processing; and manual therapy techniques, excluding spinal manipulation."

SECTION 4. G.S. 90-270.68 reads as rewritten:

"**§ 90-270.68. Establishment of Board, ~~terms of members,~~terms, vacancies, removal, meetings, compensation.**

(a) Establishment of Board. – The North Carolina Board of Occupational Therapy is created. The Board shall ~~have six members. All members shall be~~consist of seven members who are appointed by the Governor and ~~shall be~~are residents of this State at the time of and during their ~~appointment.~~appointment, as follows:

(1) Three members shall be occupational therapists and one member shall be an occupational ~~therapist assistant; each~~therapy assistant. Each of these members shall be licensed to practice in North Carolina and have practiced, taught, or engaged in research in occupational therapy for at

least three of the five years immediately preceding appointment to the Board.

(2) ~~The fifth board~~One member shall be a physician in good standing with the North Carolina Medical Board and licensed by and registered with the North Carolina Medical Board to practice ~~medicine; and~~medicine in this State.

(3) ~~the sixth board~~One member shall represent the public at large and shall be a person who is not a health care provider licensed under this ~~Chapter.~~Chapter or the spouse of a licensed health care provider.

(4) One member shall be a counselor, educator, or school-based professional certified or licensed under North Carolina law who is employed in the North Carolina Public School System and is not an occupational therapist or an occupational therapy assistant.

The ~~medical doctor, occupational therapists, and occupational therapist assistant~~occupational therapist members and the occupational therapy assistant member shall be ~~appointed by the Governor from a list compiled~~nominated by the North Carolina Occupational Therapy Association, Inc., following the use of a ~~nomination~~ procedure made available to all occupational therapists and occupational ~~therapist~~ therapy assistants licensed and residing in North Carolina. In soliciting nominations and compiling its list, the Association shall give consideration to geographic distribution, clinical specialty, and other factors that will promote representation of all aspects of occupational therapy practice. The records of the nomination procedures shall be filed with the Board and made available for a period of six months following nomination for reasonable inspection by any licensed practitioner of occupational therapy.

The physician member shall be nominated by the North Carolina Occupational Therapy Association, Inc., after consultation with the North Carolina Medical Society. The counselor, educator, or school-based professional member shall be nominated by the North Carolina Occupational Therapy Association, Inc., after consultation with the North Carolina School Counselors Association.

(b) Terms. – Members of the Board shall serve four-year staggered terms. No member shall serve more than two consecutive four-year terms, unless a member is appointed to fill a vacancy for an unexpired term, then that member may complete the unexpired term and serve one additional four-year term.

(c) Vacancies. – In the event ~~that~~ a member of the Board cannot complete a term of office, the vacancy shall be filled by appointment by the Governor, in accordance with the procedures set forth in this section, for the remainder of the unexpired term. Vacancies shall be filled by the governor within 45 days of receipt of the nominations from the North Carolina Occupational Therapy Association, Inc., or, in the case of public members, within 45 days of the receipt of notice of vacancy.

(d) 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 participating in Board business until the charges are resolved.

(e) Meetings. – Each year the Board shall meet and designate a ~~chairman~~ chairperson, a vice-chairperson, and a secretary-treasurer from among its members. The

Board may hold additional meetings upon call of the ~~chairman~~ chairperson or any two board members. A majority of the Board membership shall constitute a quorum.

(f) Compensation. – Members of the Board shall receive no compensation for their services, but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5."

SECTION 5. G.S. 90-270.69 reads as rewritten:

"**§ 90-270.69. Powers and duties of the Board.**

The Board shall have the following powers and duties:

(1) ~~Examine~~ Establish and determine the qualifications and fitness of applicants for licensure to practice occupational therapy in this ~~State;~~State.

(2) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this ~~Article;~~Article.

(2a) Communicate disciplinary actions to relevant State and federal authorities and to other state occupational therapy licensing authorities.

(3) Issue and renew, and deny, suspend, revoke or refuse to issue or renew any license under this ~~Article;~~Article.

(4) Adopt, amend, or repeal any reasonable rules or regulations necessary to carry out the purposes of this Article, including but not limited to rules establishing ethical standards of ~~practice;~~practice.

(5) Employ professional, clerical, investigative or special personnel necessary to carry out the provisions of this Article, and purchase or rent office space, equipment and ~~supplies;~~supplies.

(6) Adopt a seal by which it shall authenticate its proceedings, official records, and ~~licenses;~~licenses.

(7) Conduct administrative hearings in accordance with Chapter 150B of the General Statutes when a "contested case" as defined in G.S. 150B-2(2) arises under this ~~Article;~~Article.

(8) Establish reasonable fees for applications, ~~for examination; initial, provisional,~~limited permits, initial and renewal ~~licenses;~~licenses and other services provided by the ~~Board;~~Board.

(9) Submit an annual report to the Governor and General Assembly of all its official actions during the preceding year, together with any recommendations and findings regarding improvement of the profession of occupational ~~therapy;~~therapy.

(10) Publish and make available upon request the licensure standards prescribed under this Article and all rules and regulations established by the ~~Board;~~Board.

(11) ~~Approve educational curricula and field work experience accredited by the American Medical Association and American Occupational Therapy Association for persons seeking licensure under this Article.~~Conduct a training program as needed for new board members designed to familiarize new members with their duties."

SECTION 6. G.S. 90-270.70 reads as rewritten:

"**§ 90-270.70. Requirements for licensure.**

(a) Any individual who desires to be licensed as an occupational therapist or occupational ~~therapist~~ therapy assistant shall file a written application with the Board on forms provided by the Board, showing to the satisfaction of the Board that the applicant:

(1) Is of good moral character; and

(2) Has passed an examination approved by the Board as provided in this Article.

Applicants for licensure as an occupational therapist must also have successfully completed an accredited occupational therapy educational curriculum and the required supervised ~~field work experience of at least six months' duration.~~fieldwork as determined by the Board. Applicants for licensure as an occupational ~~therapist~~ therapy assistant must also have successfully completed an accredited occupational therapy assistant educational curriculum and the required supervised ~~field work experience of at least two months' duration.~~fieldwork as determined by the Board.

(b) Occupational therapists who are trained outside of the United States and its territories shall satisfy the examination and educational requirements as stated in subsection (a) of this section. The Board shall require these applicants to meet examination eligibility requirements as established by the credentialing body recognized by the Board before taking the examination."

SECTION 7. G.S. 90-270.71 is repealed.

SECTION 8. G.S. 90-270.72 reads as rewritten:

"**§ 90-270.72. Exemption from requirements.**

~~(a) The Board shall waive the examination, education, and field work requirements of G.S. 90-270.70 and shall grant a license to any applicant who presents evidence satisfactory to the Board that he or she has been engaged in the practice of occupational therapy as an occupational therapist or occupational therapist assistant before September 1, 1984. Proof of such actual practice shall be presented to the Board as established by regulation. To qualify for exemption under this section, the applicant shall file an application for licensure no later than September 1, 1985.~~

~~(b)~~ The Board may ~~grant a license without examination to any applicant who~~ exempt an applicant from certain licensure requirements if the applicant presents proof satisfactory to the Board of current licensure as an occupational therapist or occupational ~~therapist~~ therapy assistant in another state or the District of Columbia, Puerto Rico, or Guam, provided the other jurisdiction's licensure standards are considered by the Board to be substantially equivalent to or higher than those prescribed in this Article."

SECTION 9. G.S. 90-270.73 reads as rewritten:

"**§ 90-270.73. Issuance of license.**

(a) The Board shall issue a license to any individual who meets the requirements of this Article upon payment of the license fee prescribed in G.S. 90-270.77.

(b) Any individual licensed as an occupational therapist under this Article may use the words "occupational therapist" and may use the letters "O.T." or ~~"O.T.R./L."~~"O.T./L.' in connection with his or her name or place of business.

(c) Any individual licensed as an occupational ~~therapist~~ therapy assistant under this Article may use the words "occupational ~~therapist~~ therapy assistant" and may use the ~~letter~~ letters "O.T.A." or ~~"C.O.T.A./L."~~'O.T.A./L.' in connection with his or her name or place of business.

(d) Any individual possessing a limited permit to practice occupational therapy may use the words 'occupational therapy limited permittee' or 'occupational therapy assistant limited permittee' and may use the letters 'O.T./L.P.' or 'O.T.A./L.P.' in connection with his or her name or place of business."

SECTION 10. G.S. 90-270.74 reads as rewritten:

"**§ 90-270.74. ~~Provisional licenses.~~Limited permits.**

The Board may grant a ~~provisional license for a period not exceeding nine months to any~~limited permit to an individual who has successfully completed the educational and field work ~~experience~~ requirements ~~and has made application to take the examination~~ for examination but has not yet taken or received the results of the examination required under G.S. 90-270.70. A ~~provisional license~~limited permit shall allow the individual to practice as an occupational therapist or occupational ~~therapist~~ therapy assistant under the supervision of an occupational therapist licensed in this ~~State and shall be valid until revoked by the Board. A provisional license~~State. A limited permit shall expire after 120 days, when the individual is issued a license under G.S. 90-270.73, or if the individual is notified that he or she did not pass the examination, whichever occurs ~~shall not be issued to applicant who has failed the examination in this State or another jurisdiction.~~first. The provisions of this section shall expire October 1, 2007."

SECTION 11. G.S. 90-270.75(a) reads as rewritten:

"(a) Licenses issued under this Article shall be subject to annual renewal upon completion of ~~such~~ continuing education and competency requirements as may be required by the Board, upon the payment of a renewal fee specified under G.S. 90-270.77 and in compliance with this Article, and shall expire unless renewed in the manner prescribed by the Board. The Board may provide for the late renewal of a license upon the payment of a late fee in accordance with G.S. 90-270.77, but no such late renewal may be granted more than five years after a license expires."

SECTION 12. G.S. 90-270.76 reads as rewritten:

"**§ 90-270.76. Suspension, revocation and refusal to renew license.**

(a) The Board may deny or refuse to renew a license, may suspend or revoke a license, or may impose probationary conditions on a license if the licensee or applicant for licensure has engaged in any of the following conduct:

(1) ~~Employment of fraud, deceit or misrepresentation in obtaining or attempting to obtain a license, or the renewal thereof;~~Obtaining a license by means of fraud, misrepresentation, or concealment of material facts.

(2) ~~Conviction of or a plea of guilty or nolo contendere to any crime involving moral turpitude;~~Engaging in unprofessional conduct pursuant to rules established by the Board or violating the Code of Ethics adopted and published by the Board.

(3) ~~Adjudication of insanity or incompetency, until proof of recovery from the condition can be established;~~Having been convicted of or pleaded guilty or nolo contendere to a crime involving moral turpitude or any crime which indicates that the occupational therapist or occupational therapy assistant is unfit or incompetent to practice occupational therapy or that the occupational therapist or occupational therapy assistant has deceived or defrauded the public.

(4) Engaging in any act or practice violative of any of the provisions of this Article or any rule or regulation adopted by the Board ~~hereunder,~~ or aiding, abetting or assisting any person in such a ~~violation;~~violation.

(5) Committing an act or acts of malpractice, gross negligence or incompetence in the practice of occupational ~~therapy;~~therapy.

(6) Practicing as a licensed occupational therapist or occupational ~~therapist~~ therapy assistant without a current ~~license;~~license.

(7) Engaging in conduct that could result in harm or injury to the public.

(8) Having an occupational therapy license revoked or suspended or other disciplinary action taken whether in this State or another jurisdiction.

(9) Being unfit or incompetent to practice occupational therapy by reason of deliberate or negligent acts or omissions regardless of whether actual injury to a patient is established.

(b) ~~Such~~ The denial, refusal to renew, suspension, revocation or imposition of probationary conditions upon a license may be ordered by the Board after a hearing held in accordance with G.S. Chapter 150B and rules adopted by the Board. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year."

SECTION 13. G.S. 90-270.77 reads as rewritten:

"**§ 90-270.77. Fees.**

The Board shall adopt and publish, in the manner established by its rules and regulations, fees reasonably necessary to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed ~~ten dollars ($10.00);~~twenty-five dollars ($25.00).

(2) For ~~examination, reexamination, or~~ issuance of ~~a license~~ an initial license, a fee not to exceed ~~one hundred dollars ($100.00);~~two hundred dollars ($200.00).

(3) For the renewal of a license, a fee not to exceed ~~fifty dollars ($50.00);~~one hundred dollars ($100.00).

(4) For the late renewal of a license, a fee not to exceed ~~fifty dollars ($50.00);~~one hundred dollars ($100.00).

(5) For a ~~provisional license,~~limited permit, a fee not to exceed ~~thirty-five dollars ($35.00); and~~fifty dollars ($50.00). This fee shall expire October 1, 2007.

(6) For copies of Board rules and licensure standards, charges not ~~exceeding~~ to exceed the actual cost of printing and mailing."

SECTION 14. G.S. 90-270.78 reads as rewritten:

"**§ 90-270.78. False representation of license prohibited.**

(a) It is unlawful for any person who is not licensed in accordance with this Article or whose license has been suspended, revoked or not renewed by the Board to:

(1) Engage in the practice of occupational ~~therapy;~~therapy.

(2) Orally, in writing, in print or by sign, or in any other manner, directly or by implication, represent that he or she is engaging in occupational ~~therapy; or~~therapy.

(3) Use in connection with his or her name or place of business the words ~~"occupational therapist" or "occupational therapist assistant";~~'occupational therapist', 'occupational therapy assistant', 'occupational therapist limited permittee', or 'occupational therapy assistant limited permittee', or the letters "O.T.", ~~"O.T.R./L.",~~'O.T./L.', "O.T.A.", ~~or "C.O.T.A./L."~~'O.T.A./L.', 'O.T./L.P.', or 'O.T.A./L.P.' or any other words, letters, abbreviations or insignia indicating or implying that the person is an occupational ~~therapist or~~therapist, occupational ~~therapist assistant.~~therapy assistant, occupational therapist limited permittee, or occupational therapy assistant limited permittee.

(b) Any person who resides in another state or foreign country and who, by use of electronic or other medium, performs any of the acts described as the practice of occupational therapy pursuant to this Article, but is not licensed pursuant to this Article, shall be regarded as practicing occupational therapy without a North Carolina license and is subject to the provisions of this Article and appropriate regulation by the Board."

SECTION 15. Article 18D of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-270.80A. Civil penalties, disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Board may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of 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, the Board shall 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 and rules adopted by the Board.

(d) Costs. – The Board may assess the costs of disciplinary actions against any person found to be in violation of this Article or rules adopted by the Board."

SECTION 16. G.S. 90-270.81 reads as rewritten:

"**§ 90-270.81. Persons and practices not affected.**

Nothing in this Article shall be construed to prevent or restrict:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State from performing work incidental to the practice of that profession or occupation as long as the person does not represent himself or herself as an occupational therapist or occupational ~~therapist assistant;~~therapy assistant.

(2) Any person employed as an occupational therapist or occupational ~~therapist~~ therapy assistant by the government of the United States, if he or she provides occupational therapy solely under the direction or control of the organization by which he or she is ~~employed;~~employed.

(3) Any person pursuing a course of study leading to a degree or certificate in occupational therapy at an accredited or approved educational program if ~~such~~ the activities and services constitute a part of a supervised course of study and if the person is designated by a title which clearly indicates his or her status as a student or ~~trainee;~~trainee.

(4) Any person fulfilling the supervised ~~field work~~fieldwork experience required for licensure under this Article if the person is designated by a ~~title which~~title, which clearly indicates his or her status as a student or ~~trainee;~~trainee.

(5) Occupational therapists or occupational ~~therapist~~ therapy assistants licensed in other jurisdictions who are ~~teaching~~ consulting, teaching, or participating in special occupational therapy education projects, demonstrations or courses in this State, provided their evaluation and treatment of patients is minimal.

(6) The practice of occupational therapy by an occupational therapist or occupational therapy assistant licensed in another jurisdiction who comes into this State, whether in person or by use of any electronic or other medium, on an irregular basis, to consult with a North Carolina licensed occupational therapist or occupational therapy assistant or to consult with faculty at an academic facility about education and training. This shall not apply to occupational therapists or occupational therapy assistants residing in a neighboring state and regularly practicing in this State."

SECTION 17. All members serving on the North Carolina Board of Occupational Therapy on the effective date of this act shall complete their current terms. Upon completion of their current terms, the occupational therapist members shall serve one additional term of either three or four years as follows: the occupational therapist member who served the longest may serve an additional three year term; the other two

occupational therapist members, the occupational therapy assistant member, and the physician member shall be eligible to serve one additional four-year term. The Governor shall appoint a new public member to serve a four-year term. The Governor shall also appoint the counselor, educator, or school-based professional member for a four-year term pursuant to G.S. 90-270.68(a)(4), as enacted in Section 4 of this act, to begin October 1, 2005. Members appointed thereafter shall serve four-year terms.

SECTION 18. This act is effective when it becomes law.

HOUSE BILL 707

Short Title:	Amend Star-Rated Licensure/Child Care Fac.-AB	(Public)
Sponsors:	Representatives Alexander, McLawhorn (Primary Sponsors); Farmer-Butterfield, Glazier, Insko, and Luebke.	
Referred to:	Children, Youth and Families.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF CHILD DEVELOPMENT, TO STRENGTHEN THE LAWS REGULATING STAR-RATED LICENSURE FOR CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-90 reads as rewritten:

"**§ 110-90. Powers and duties of Secretary of Health and Human Services.**

The Secretary shall have the following powers and duties under the policies and rules of the Commission:

(1) To administer the licensing program for child care facilities.

(1a) To establish a fee for the licensing of child care centers. The fee does not apply to a religious-sponsored child care center operated pursuant to a letter of compliance. The amount of the fee may not exceed the amount listed in this subdivision.

Capacity of Center	Maximum Fee
12 or fewer children	$ 35.00
13-50 children	$125.00
51-100 children	$250.00
101 or more children	$400.00

(2) To obtain and coordinate the necessary services from other State departments and units of local government which are necessary to implement the provisions of this Article.

(3) To employ the administrative personnel and staff as may be necessary to implement this Article where required services, inspections or reports are not available from existing State agencies and units of local government.

(4) To issue a rated license to any child care facility which meets the standards established by this Article. The rating shall be based on the following:

a. Before January 1, 2008, for any child care facility currently holding a license of two to five stars, the rating shall be based on program standards, education levels of staff, and compliance history of the child care ~~facility.~~facility. By January 1, 2008, the rating shall be based on program standards and education levels of staff.

b. Effective January 1, 2006, for any new license issued to a child care facility with a rating of two to five stars, the rating shall be based on program standards and education levels of staff.

c. By January 1, 2008, for any child care facility to maintain a license or Notice of Compliance, the child care facility shall have a compliance history of at least seventy-five percent (75%), as assessed by the Department. When a child care facility fails to maintain a compliance history of at least seventy-five percent (75%) for the past 18 months or during the length of time the facility has operated, whichever is less, as assessed by the Department, the Department may issue a provisional license or Notice of Compliance.

d. Effective January 1, 2006, for any new license or Notice of Compliance issued to a child care facility, the facility shall maintain a compliance history of at least seventy-five percent (75%), as assessed by the Department. When a child care facility fails to maintain a compliance history of at least seventy-five percent (75%) for the past 18 months or during the length of time the facility has operated, whichever is less, as assessed by the Department, the Department may issue a provisional license or Notice of Compliance.

e. The Department shall provide additional opportunities for child care providers to earn points for program standards and education levels of staff.

(5) To revoke the license of any child care facility that ceases to meet the standards established by this Article and rules on these standards adopted by the Commission, or that demonstrates a pattern of noncompliance with this Article or the rules, or to deny a license to any applicant that fails to meet the standards or the rules. These revocations and denials shall be done in accordance with the procedures set out in G.S. 150B and this Article and rules adopted by the Commission.

(6) To prosecute or defend on behalf of the State, through the office of the Attorney General, any legal actions arising out of the administration or enforcement of this Article.

(7) To promote and coordinate educational programs and materials for operators of child care facilities which are designed to improve the quality of child care available in the State, using the resources of other State and local agencies and educational institutions where appropriate.

(8) Repealed by Session Laws 1997-506, s. 5.

(9) To levy a civil penalty pursuant to G.S. 110-103.1, or an administrative penalty pursuant to G.S. 110-102.2, or to order summary suspension of a license. These actions shall be done in accordance with the procedures set out in G.S. 150B and this Article and rules adopted by the Commission.

(10) To issue final agency decisions in all G.S. 150B contested cases proceedings filed as a result of actions taken under this Article including, but not limited to the denial, revocation, or suspension of a license or the levying of a civil or administrative penalty.

(11) To issue a license to any child care arrangement that does not meet the definition of child care facility in G.S. 110-86 whenever the operator of the arrangement chooses to comply with the requirements of this Article and the rules adopted by the Commission and voluntarily applies for a child care facility license. The Commission shall adopt rules for the issuance or removal of the licenses."

SECTION 2. This act becomes effective January 1, 2006.

HOUSE BILL 707:
Amend Star-Rated Licensure/Child Care Fac.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Representatives Alexander and McLawhorn
Date:	April 27, 2005		
Version:	First Edition	**Summary by:**	Ben Popkin Committee Counsel

SUMMARY: ***House Bill 707 would authorize the Department of Health and Human Services, Division of Child Development, to strengthen the law regulating star-rated licensure for child care facilities. The act would become effective January 1, 2006.***

CURRENT LAW: Article 7 of Chapter 110 of the General Statutes addresses Child Care Facilities[1]. The Secretary of the Department of Health and Human Services is charged with the duty of administering a licensing program for child care facilities[2], including the issuance of a 'rated license' based on program standards, education levels of staff and compliance history of the facility[3]. Article 7 created the Child Care Commission to develop policies and procedures "for the issuance of a license to any child care facility that meets all applicable standards established under this article."[4] The star-rating system utilizes a point system where points are earned based on a facility's performance in each of these three areas, with the overall point total determining the star-rating of the facility. A minimum compliance history of 60% for the previous three year period is required to maintain licensure.

BILL ANALYSIS: The bill would apply to those facilities holding or applying for licenses for facilities of two to five stars. The bill would remove compliance history from the star-rating equation, making it a basic requirement for licensure. The star rating of a child care facility would be based on points earned in the areas of program standards and staff education. A higher minimum compliance requirement would be set (75% rather than the current 60%) over a shorter period of 18 months (rather than the current three years). Facilities failing to meet the 75% compliance history standard would be eligible to receive a provisional license to allow them to correct the compliance deficiencies and come into compliance.

The new star-rating scheme (awarding points only in the areas of program standards and staff education), new 75% standard, and new 18 month time period would be phased in. Facilities applying for new licenses on or after January 1, 2006 would be required to comply with these new standards. By January 1, 2008, all facilities would be held to the new standards.

H707-SMSS-001

[1] G.S. 110-85 through 110-107.
[2] G.S. 110-90(1).
[3] G.S. 110-90(4).
[4] G.S. 110-88(1)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1059

Short Title:	Perfusionists Licensure.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Perfusionist Licensure act.

"**§ 90-681. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-682. Definitions.**

The following definitions apply in this Article:

(1) Advisory Committee. – The North Carolina Perfusion Advisory Committee.

(2) Clinical Certified Perfusionist. – A person who has successfully completed the examination process and has been issued a certificate by the American Board of Cardiovascular Perfusion or its successor organization.

(3) Extracorporeal Circulation. – The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(4) Licensee. – A person who has been issued a license to practice perfusion under this Article.

(5) Perfusion Protocols. – Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician

through collaboration with administrators, licensed perfusionists, and other health care professionals.

(6) Practice of Perfusion. – The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

"**§ 90-683. License required; exemptions.**

(a) On or after July 1, 2006, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist', 'certified clinical perfusionist', or 'provisional licensed perfusionist', use the letters 'LP', 'CCP', or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist, clinical certified perfusionist, or a provisionally licensed perfusionist unless that person is currently licensed or certified as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or

occupation and the person does not represent himself or herself as a licensed perfusionist or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-684. Perfusion Advisory Committee.**

(a) Composition and Terms. – The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of six members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 2005, as follows:

(1) The North Carolina Medical Board shall appoint three licensed perfusionists, two of whom shall serve a term of three years and one of whom shall serve a term of two years.

(2) The North Carolina Medical Board shall appoint one physician who is licensed under Article 1 of Chapter 90 of the General Statutes and is a cardiothoracic surgeon or a cardiovascular anesthesiologist, who shall serve a term of two years.

(3) The North Carolina Hospital Association shall appoint one hospital administrator, who shall serve a term of one year.

(4) The Governor shall appoint one public member who shall serve a term of one year.

Upon the expiration of the terms of the initial Committee members, members shall be appointed by the appointing authorities designated in subdivisions (1) through (4) of subsection (a) of this section for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. – Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Committee.

(c) Vacancies. – Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the

remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. – The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. – Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. – The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. – The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-685. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Determine the qualifications and fitness of applicants for licensure, provisional licensure, licensure renewal, and reciprocal licensure.

(6) Issue, renew, deny, suspend, or revoke licenses, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure, provisional licensure, reciprocal licensure, licensure renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees exist.

(12) Maintain a record of all proceedings and make available to all licensees and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-686. Qualifications for licensure.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Pays the required fee under G.S. 90-689.

(5) Is certified as a certified clinical perfusionist. An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-689.

(b) All persons licensed under this section shall practice perfusion under the supervision of a physician licensed under Article 1 of Chapter 90 of the General Statutes.

"**§ 90-687. Reciprocity.**

The Committee may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-688. Provisional license.**

The Committee may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-689. A provisional license shall allow the individual to practice perfusion under the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license 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. Provisional licenses shall be renewed in accordance with the provisions of G.S. 90-690.

"**§ 90-689. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Issuance of license	$350.00
(3)	Biennial renewal of license	$350.00
(4)	Late renewal of license	$100.00
(5)	Provisional license	$ 35.00
(6)	Copies of rules	Cost

"**§ 90-690. Renewal of licenses.**

(a) All licenses to practice perfusion shall expire two years after the date they were issued. The Committee shall send a notice of expiration to each licensee at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-689.

(b) An application for renewal of a license that has been expired for less than three years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-689. A license that has been expired for more than three years shall not be renewed, but the applicant may apply for a new license by complying with the current requirements for licensure under this Article.

"**§ 90-691. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if the applicant or licensee:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or a license to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-692. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief.

"**§ 90-693. Civil penalties; disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Committee may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of any rules adopted by the Committee. 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, the Committee shall 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 Committee shall establish a schedule of civil penalties for violations of this Article and rules adopted by the Committee.

(d) Costs. – The Committee may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Committee."

SECTION 2. Notwithstanding the requirements of this act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

SECTION 3. G.S. 90-684, as enacted in Section 1 of this act, becomes effective October 1, 2005. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1059
PROPOSED COMMITTEE SUBSTITUTE S1059-CSLU-2 [v.1]

4/22/2005 11:05:58 AM

Short Title: Perfusionists Licensure. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Perfusionist Licensure Act.

"**§ 90-681. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-682. Definitions.**

The following definitions apply in this Article:

(1) Advisory Committee. – The North Carolina Perfusion Advisory Committee.

(2) Clinical Certified Perfusionist. – A person who has successfully completed the examination process and has been issued a certificate by the American Board of Cardiovascular Perfusion or its successor organization.

(3) Extracorporeal Circulation. – The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(4) Licensee. – A person who has been issued a license to practice perfusion under this Article.

(5) Perfusion Protocols. – Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician through collaboration with administrators, licensed perfusionists, and other health care professionals.

(6) Practice of Perfusion. – The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

"**§ 90-683. License required; exemptions.**

(a) On or after July 1, 2006, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist' or 'provisional licensed perfusionist', use the letters 'LP' or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist or a provisionally licensed perfusionist unless that person is currently licensed as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or

occupation and the person does not represent himself or herself as a licensed perfusionist or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-684. Perfusion Advisory Committee.**

(a) Composition and Terms. – The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of seven members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 2005, as follows:

(1) The North Carolina Medical Board shall appoint three licensed perfusionists, two of whom shall serve a term of three years and one of whom shall serve a term of two years.

(2) The North Carolina Medical Board shall appoint one physician who is licensed under Article 1 of Chapter 90 of the General Statutes and is a cardiothoracic surgeon or a cardiovascular anesthesiologist, who shall serve a term of two years.

(3) The North Carolina Hospital Association shall appoint two hospital administrators, one of whom shall serve a term of two years and one of whom shall serve a one-year term.

(4) The Governor shall appoint one public member who shall serve a one-year term.

Upon the expiration of the terms of the initial Committee members, members shall be appointed by the appointing authorities designated in subdivisions (1) through (4) of subsection (a) of this section for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. – Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Committee.

(c) Vacancies. – Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be

filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. – The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. – Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. – The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. – The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-685. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Determine the qualifications and fitness of applicants for licensure, provisional licensure, licensure renewal, and reciprocal licensure.

(6) Issue, renew, deny, suspend, or revoke licenses, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure, provisional licensure, reciprocal licensure, licensure renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees exist.

(12) Maintain a record of all proceedings and make available to all licensees and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-686. Qualifications for licensure.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Pays the required fee under G.S. 90-689.

(5) Is certified as a certified clinical perfusionist. An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-689.

(b) All persons licensed under this section shall practice perfusion under the supervision of a physician licensed under Article 1 of Chapter 90 of the General Statutes.

"**§ 90-687. Reciprocity.**

The Committee may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-688. Provisional license.**

The Committee may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-689. A provisional license shall allow the individual to practice perfusion under the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license 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. Provisional licenses shall be renewed in accordance with the provisions of G.S. 90-690.

"**§ 90-689. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Issuance of license	$350.00
(3)	Biennial renewal of license	$350.00
(4)	Late renewal of license	$100.00
(5)	Provisional license	$ 35.00
(6)	Copies of rules	Cost

"**§ 90-690. Renewal of licenses.**

(a) All licenses to practice perfusion shall expire two years after the date they were issued. The Committee shall send a notice of expiration to each licensee at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-689.

(b) An application for renewal of a license that has been expired for less than three years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-689. A license that has been expired for more than three years shall not be renewed, but the applicant may apply for a new license by complying with the current requirements for licensure under this Article.

"**§ 90-691. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if the applicant or licensee:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or a license to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-692. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief.

"**§ 90-693. Civil penalties; disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Committee may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of any rules adopted by the Committee. 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, the Committee shall 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 Committee shall establish a schedule of civil penalties for violations of this Article and rules adopted by the Committee.

(d) Costs. – The Committee may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Committee.

"**§ 90-694. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

SECTION 2. Notwithstanding the requirements of this act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

SECTION 3. G.S. 90-684, as enacted in Section 1 of this act, becomes effective October 1, 2005. The remainder of this act is effective when it becomes law.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 27, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
M MANN	NCCA
Tom Schoenvogel	NCCA
Dr. Dennis T. Heed	NCCA
ANN LORE	DUHS
STEVE KEENE	NC MEDICAL SOCIETY
DAVID BARNES	Poyner Spruill
Rob Lamm	HHS
Christine Crain	Wakemed
ZEB ALLEY	ALLEY ASSOCIATES
JOHN GOODMAN	
IAN SHEARER	NCSP

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 27, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Candace Doyle	North Carolina Society of Perfusionists
Darlene Sekeres	NC. Physical Therapy Association
Laurie King	NCPTA
DAN DORE	NCPTA
Ginny Jo Horne	NCMS
Karen Johnson	Smith Anderson
Stella McKinney	NC DHHS
Peggy Ball	NC DHHS
Jane Lockleer	NC DHHS
John Mc[illegible]	Covance
Suzanne Brefley	Governors Office
Lee Hyler	KCCH

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 27, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DIANA JONES, RN, BSN	WAKE FOREST UNIV. NURSE ANESTHESIA SCHOOL
Brandi Flanagan, RN, CRNA	Wake Forest Univ. Baptist Medical Center Nurse Anesthesia Prog.
KAREN HALL, RN, BSN	Wake Forest Univ. Baptist Medical Center School of NURSE ANESTHESIA
Sarah Norris	Total Child Care, Wilmington, N.C.
WILLIAM WALSH, OTR/L, CHT	HAND + REHABILITATION SPECIALISTS OF NC
Jami Fitzgerald	NCFPC
Jessica Sage	NCFPC
Rebecca Tendman	NCACC
Scott K. Garrison, MD	NC Medical Society Doctor of the Day
	NCSA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 27, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Karen Gillespie	BMS
Heidi Dorfman	NCOTA
Brenda Kennell	NCBOT
Carol Sieber	NCOTA
Bill Walsh	NCOTA
Charles Wilkins	NCBOT
Evelyn Hawthorne	NCOTA Lobbyist

Senate Health Care Committee
Wednesday, May 4, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 1059	Perfusionists Licensure.	Senator Purcell
SB 665	County Medicaid Billing Systems.	Senator Hartsell
HB 780	Need-Based Nursing Scholarships.-AB	Representative Yongue
HB 277	Establish Child Assessment Responses.	Representative Carney Representative Alexander Representative Glazier
SB 804	Public Health Task Force/Accred. Recommend.	Senator Hartsell

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 04, 2005

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

FAVORABLE

S.B. **804** Public Health Task Force/Accred. Recommend.
Sequential Referral: None
Recommended Referral: None

H.B.(CS #1) **277** Establish Child Assessment Responses.
Sequential Referral: None
Recommended Referral: None

H.B.(CS #1) **780** Need-Based Nursing Scholarships.-AB
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 3

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, May 05, 2005

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

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

S.B.	**665**	County Medicaid Billing Systems.	
		Draft Number:	65312
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes
S.B.	**1059**	Perfusionists Licensure.	
		Draft Number:	65313
		Sequential Referral:	Finance
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

Senate Health Care Committee
Wednesday May 4, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 4, 2005, in Room 544 of the Legislative Office Building, with thirteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator William R. Purcell, Co-chairs, welcomed the committee members present and introduced the pages.

Senator Bingham asked Senator Hartsell to bring Senate Bill 804, ***Public Health Task Force/Accred. Recommend.***, to be heard first. The bill is a recommendation of the Public Health Task Force. It is a performance orientated accreditation program. The accreditation itself would be housed in the Institute of Public Health at Chapel Hill. Senator Dorsett asked if there are other states with accreditation. Senator Hartstell stated there are other states, however there are many different forms. Senator Lucas asked what consequences counties would suffer if they were not accredited. Senator Hartsell answered at present there are no consequences. Senator Dorsett moved for a favorable report and the bill passed.

Senator Bingham introduced the Nurse of the Day, Renee Payne from High Point and the Doctor of the Day, Dr. Melanie Walker, Pediatrician from Raleigh.

Rep. Yongue was recognized to present HB 780, ***Need-Based Nursing Scholarships.-AB***. He said the bill modifies the process in which the need based scholarship and loan program are administered. The bill places all the responsibilities for the selection of scholarship recipients with the State Education Assistant Authority, who already administers this program. It promotes more uniform administration of these scholarship programs. Steve Brooks, Executive Director of the State Education Assistants Authority, stated these changes were recommended to help streamline the administration. The changes are more in line with the way other programs are done. Senator Dannley moved for a favorable report. The bill passed.

Senator Purcell presented SB 1059, ***Perfusionists Licensure***, which had a sequential referral to the Finance Committee and a Proposed Committee Substitute. The bill has already been through the Licensing Committee. This bill is to license people to operate the machines that control your heart and lungs, when they are not working, during heart and lung surgery. It gives the perfusionists a license so no one can come in and falsely claim to be a perfusionist. Staff Attorneys stated there would have to be a motion to hear the PCS. Senator Dannley made the motion, which passed. Senator Purcell asked Ian Shearer, Chief Perfusionist at Duke Medical Center and President Elect of the NC Society of Perfusionist to answer any questions. Dave Christaldi the current president of the NC Society of Perfusionist and Candace Doyle, Secretary-Treasury joined him. Senator Forrester asked if there was a problem with unqualified perfusionist in NC at this time. Mr. Shearer stated there is always that potential. Certification is through the American Board of Cardiovascular Perfusion and is a voluntary certification

process, although most hospitals require staff to do this, it is not an absolute requirement. There is no measure in place to dismiss a perfusionist not practicing in accordance with this voluntary certification process. Senator Forrester asked if there is a surplus of perfusions in NC at this time. Mr. Shearer stated there is currently between 88-92 practicing in NC today. Currently the job market is balanced. Senator Forrester asked if someone not licensed as a perfusionist is still allowed to work under cardio-thoracic surgeons under this bill. Mr. Shearer stated the exceptions would be some government employees who work for the veteran's hospital. Senator Dorsett stated she saw where the committee would conduct investigations of violations and also would determine what the fees will be; she inquired where the funds would go. Senator Purcell stated the fees would be used to pay the expenses of the advisory committee. Senator Dannley asked if there were any unlicensed perfusionists today practicing. Mr. Shearer answered today there are no licensed perfusionists practicing in NC, nationally there are twelve states that have licensures. Mr. Shearer stated the majority of perfusionists practicing in NC are certified by the American Board of Cardiovascular Perfusion. Senator Dannley asked to send in a technical amendment. The amendment changed the definition of practice of profusion, requested by The Medical Society. The amendment passed. Senator Allran asked who was for and against this bill. Senator Purcell stated that no one had come to him against the bill. The hospital association is for the bill. Hugh Tilson, NC Hospital Association, supports the legislation because it will facilitate quality assurance activity in hospitals and insure hospitals are hiring qualified people. Senator Forrester asked the staff what the difference between the PCS and the original bill was other than the third party reimbursement. Ben Popkin, Staff Attorney stated that was the only change other than it raised the committee members from six to seven. Senator Dannley moved for a favorable report, to roll the amendment into a new Proposed Committee Substitute, unfavorable to the original bill and favorable to the new Committee Substitute with a sequential referral to Finance. The bill passed.

Senator Bingham recognized Representative Glazier, to present House Bill 277, ***Establish Child Assessment Response.*** He stated that House Bill 277 deals with the issue of trying to simply resolve a legal problem in the statutes with regard to the multiple response system developed in NC. NC Department of Social Services and the Division of Social Services at HHS have been exploring ways to deal with and improve NC response in investigating and accessing abuse, neglect, and dependency cases. What has developed is a system that has received national attention called The Multiple Response System, which tries to create differing levels of response for neglect case, which occupy 80% of the cases. Senator Allran asked why do we need a statue to have this. Representative Glazier responded it is trying to conform the old statue to the new system. Senator Dorsett moved for a favorable reported. The bill passed.

Senator Bingham asked for a motion to hear the PCS for Senate Bill 665, ***County Medicaid Billing Systems***. Senator Hartsell made the motion, which was adopted. Senator Hartsell was recognized to explain the bill. There are two public health authorities in North Carolina now, although there is a statute that would permit other public health agencies to become authorities if they choose. The two authorities are in

Cabarrus County and Hertford County. The bill will do two things, one to permit the county to enter into an agreement, this is permissive not mandatory, with an agency to establish a health information system. Currently in NC there is a reporting system for health services information. It has been in existence for an extraordinary period of time. That system requires local health departments to report both their clinical services and other activities separately even though they may be done in the same fashion. A number of counties have found private venders to try to create some efficiency associated in merging these reporting functions. They also are involved with reimbursements for Medicaid. Local Health Departments have been promised for fifteen years a statewide system. Senator Allran asked if this bill would allow public health boards to contract with somebody in India to provide the service or in other places and take away jobs from North Carolinians. Senator Hartsell stated they probable could. The ones that are in place now are in the United States. This is dealing with the software delivery system, and the state could have the same situation. The state plan RFP is 350 pages long. This is just acquiring a software system with local input. Senator Dorsett asked the difference between an authority and a public health board. Senator Hartsell responded, the authority is appointed by the County Commissioners like a health board. The authority operates as a public body but with an independent board and the health director serves at the pleasure of the board. The primary differences are the way they contract services, contracting for services for a public health board are contracts with the county, however, contracts with an authority are contracts with the authority. The authority has the ability to go out and seek grants independently for their operations. Senator Dannley asked why they would want to contract the service out. Senator Jacumin asked could they not specify that the private providers be located in the United States. Senator Jacumin would like to amend the bill stating this, however, staff was not sure about conflicts with interstate commerce. Staff will check on this and do an amendment for the floor if feasible. Senator Dannley made a motion unfavorable as to original bill but favorable to the Proposed Committee Substitute. The bill passed.

The meeting adjourned at 12:00 Noon.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1059

Short Title:	Perfusionists Licensure.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Perfusionist Licensure act.

"**§ 90-681. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-682. Definitions.**

The following definitions apply in this Article:

(1) Advisory Committee. – The North Carolina Perfusion Advisory Committee.

(2) Clinical Certified Perfusionist. – A person who has successfully completed the examination process and has been issued a certificate by the American Board of Cardiovascular Perfusion or its successor organization.

(3) Extracorporeal Circulation. – The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(4) Licensee. – A person who has been issued a license to practice perfusion under this Article.

(5) Perfusion Protocols. – Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician

through collaboration with administrators, licensed perfusionists, and other health care professionals.

(6) Practice of Perfusion. – The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

"**§ 90-683. License required; exemptions.**

(a) On or after July 1, 2006, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist', 'certified clinical perfusionist', or 'provisional licensed perfusionist', use the letters 'LP', 'CCP', or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist, clinical certified perfusionist, or a provisionally licensed perfusionist unless that person is currently licensed or certified as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or

occupation and the person does not represent himself or herself as a licensed perfusionist or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-684. Perfusion Advisory Committee.**

(a) Composition and Terms. – The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of six members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 2005, as follows:

(1) The North Carolina Medical Board shall appoint three licensed perfusionists, two of whom shall serve a term of three years and one of whom shall serve a term of two years.

(2) The North Carolina Medical Board shall appoint one physician who is licensed under Article 1 of Chapter 90 of the General Statutes and is a cardiothoracic surgeon or a cardiovascular anesthesiologist, who shall serve a term of two years.

(3) The North Carolina Hospital Association shall appoint one hospital administrator, who shall serve a term of one year.

(4) The Governor shall appoint one public member who shall serve a term of one year.

Upon the expiration of the terms of the initial Committee members, members shall be appointed by the appointing authorities designated in subdivisions (1) through (4) of subsection (a) of this section for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. – Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Committee.

(c) Vacancies. – Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the

remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. – The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. – Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. – The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. – The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-685. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Determine the qualifications and fitness of applicants for licensure, provisional licensure, licensure renewal, and reciprocal licensure.

(6) Issue, renew, deny, suspend, or revoke licenses, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure, provisional licensure, reciprocal licensure, licensure renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees exist.

(12) Maintain a record of all proceedings and make available to all licensees and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-686. Qualifications for licensure.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Pays the required fee under G.S. 90-689.

(5) Is certified as a certified clinical perfusionist. An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-689.

(b) All persons licensed under this section shall practice perfusion under the supervision of a physician licensed under Article 1 of Chapter 90 of the General Statutes.

"**§ 90-687. Reciprocity.**

The Committee may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-688. Provisional license.**

The Committee may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-689. A provisional license shall allow the individual to practice perfusion under the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license 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. Provisional licenses shall be renewed in accordance with the provisions of G.S. 90-690.

"**§ 90-689. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Issuance of license	$350.00
(3)	Biennial renewal of license	$350.00
(4)	Late renewal of license	$100.00
(5)	Provisional license	$ 35.00
(6)	Copies of rules	Cost

"**§ 90-690. Renewal of licenses.**

(a) All licenses to practice perfusion shall expire two years after the date they were issued. The Committee shall send a notice of expiration to each licensee at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-689.

(b) An application for renewal of a license that has been expired for less than three years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-689. A license that has been expired for more than three years shall not be renewed, but the applicant may apply for a new license by complying with the current requirements for licensure under this Article.

"**§ 90-691. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if the applicant or licensee:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or a license to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-692. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief.

"**§ 90-693. Civil penalties; disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Committee may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of any rules adopted by the Committee. 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, the Committee shall 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 Committee shall establish a schedule of civil penalties for violations of this Article and rules adopted by the Committee.

(d) Costs. – The Committee may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Committee."

SECTION 2. Notwithstanding the requirements of this act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

SECTION 3. G.S. 90-684, as enacted in Section 1 of this act, becomes effective October 1, 2005. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 5/4/04

S. B. No. 1059 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE X

Rep.)
Sen.) Dannelly

1 moves to amend the bill on page 2, line 5
2 ( ) WHICH CHANGES THE TITLE
3 by deleting the word "Functions" and
4 inserting the following phrase in its
5 place:
6 "Functions, under the supervision
7 of a licensed physician,"
8
9 and on page 2 line 10 by deleting the
10 Following:
11 "systems under the supervision of a
12 licensed physician."
13
14 and inserting the Following phrase in its place;
15 "Systems during any medical situation
16 where it is necessary to support or
17 replace the patient's cardiopulmonary or
18 circulatory function."
19

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1059
PROPOSED COMMITTEE SUBSTITUTE S1059-CSLU-2 [v.1]

4/22/2005 11:05:58 AM

Short Title: Perfusionists Licensure. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Perfusionist Licensure Act.

"**§ 90-681. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-682. Definitions.**

The following definitions apply in this Article:

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(3) Extracorporeal Circulation. – The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(4) Licensee. – A person who has been issued a license to practice perfusion under this Article.

(5) Perfusion Protocols. – Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician through collaboration with administrators, licensed perfusionists, and other health care professionals.

(6) Practice of Perfusion. – The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

"**§ 90-683. License required; exemptions.**

(a) On or after July 1, 2006, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist' or 'provisional licensed perfusionist', use the letters 'LP' or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist or a provisionally licensed perfusionist unless that person is currently licensed as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or

occupation and the person does not represent himself or herself as a licensed perfusionist or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-684. Perfusion Advisory Committee.**

(a) Composition and Terms. – The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of seven members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 2005, as follows:

(1) The North Carolina Medical Board shall appoint three licensed perfusionists, two of whom shall serve a term of three years and one of whom shall serve a term of two years.

(2) The North Carolina Medical Board shall appoint one physician who is licensed under Article 1 of Chapter 90 of the General Statutes and is a cardiothoracic surgeon or a cardiovascular anesthesiologist, who shall serve a term of two years.

(3) The North Carolina Hospital Association shall appoint two hospital administrators, one of whom shall serve a term of two years and one of whom shall serve a one-year term.

(4) The Governor shall appoint one public member who shall serve a one-year term.

Upon the expiration of the terms of the initial Committee members, members shall be appointed by the appointing authorities designated in subdivisions (1) through (4) of subsection (a) of this section for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. – Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Committee.

(c) Vacancies. – Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be

filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. – The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. – Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. – The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. – The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-685. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Determine the qualifications and fitness of applicants for licensure, provisional licensure, licensure renewal, and reciprocal licensure.

(6) Issue, renew, deny, suspend, or revoke licenses, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure, provisional licensure, reciprocal licensure, licensure renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees exist.

(12) Maintain a record of all proceedings and make available to all licensees and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-686. Qualifications for licensure.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Pays the required fee under G.S. 90-689.

(5) Is certified as a certified clinical perfusionist. An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-689.

(b) All persons licensed under this section shall practice perfusion under the supervision of a physician licensed under Article 1 of Chapter 90 of the General Statutes.

"**§ 90-687. Reciprocity.**

The Committee may grant, upon application and payment of proper fees. a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-688. Provisional license.**

The Committee may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-689. A provisional license shall allow the individual to practice perfusion under the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license 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. Provisional licenses shall be renewed in accordance with the provisions of G.S. 90-690.

"**§ 90-689. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Issuance of license	$350.00
(3)	Biennial renewal of license	$350.00
(4)	Late renewal of license	$100.00
(5)	Provisional license	$ 35.00
(6)	Copies of rules	Cost

"**§ 90-690. Renewal of licenses.**

(a) All licenses to practice perfusion shall expire two years after the date they were issued. The Committee shall send a notice of expiration to each licensee at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-689.

(b) An application for renewal of a license that has been expired for less than three years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-689. A license that has been expired for more than three years shall not be renewed, but the applicant may apply for a new license by complying with the current requirements for licensure under this Article.

"**§ 90-691. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if the applicant or licensee:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or a license to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-692. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief.

"**§ 90-693. Civil penalties; disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Committee may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of any rules adopted by the Committee. 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, the Committee shall 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 Committee shall establish a schedule of civil penalties for violations of this Article and rules adopted by the Committee.

(d) Costs. – The Committee may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Committee.

"**§ 90-694. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

SECTION 2. Notwithstanding the requirements of this act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

SECTION 3. G.S. 90-684, as enacted in Section 1 of this act, becomes effective October 1, 2005. The remainder of this act is effective when it becomes law.

SENATE BILL 1059: Perfusionists Licensure

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	April 27, 2005
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin Committee Counsel
Version:	First Edition S1059-CSSS		

SUMMARY: ***Senate Bill 1059 would enact Article 40 of Chapter 90 of the General Statutes requiring licensure of perfusionists. Article 40 – the Perfusionist Licensure Act, would create the North Carolina Perfusion Advisory Committee and would authorize the Committee to determine licensure qualifications and fees and to assess civil penalties for violation of provisions of the act. The bill would also establish minimum qualifications for licensure and set maximum licensure fees.***

The Proposed Committee Substitute would increase the membership of the Committee from six to seven members, would update terminology to reflect the licensed status that perfusionists would have, and would clarify that the bill would not require direct third-party reimbursement to licensed perfusionists.

BILL ANALYSIS: Senate Bill 1059 would enact a new Article of Chapter 90 (Medicine and Allied Occupations) of the General Statutes. Article 40 – the Perfusionist Licensure Act would set forth the following:

Mandatory Licensure – as of July 1, 2006, a current license under the provisions of this Article would be required for a person to practice as a 'licensed perfusionist' (LP) or as a 'provisional licensed perfusionist' (PLP). Several groups of health care personnel would be exempted from this requirement: perfusionists working for the United States government; students enrolled in accredited perfusion education programs if services are supervised by a licensed perfusionist and are part of their studies; persons performing autotransfusion or blood conservation techniques under the supervision of a licensed physician; and persons registered, certified, credentialed or licensed to engage in another occupation or profession in the State if they are performing work incidental to the practice of that profession and are not representing themselves as being a LP or PLP.

North Carolina Perfusion Advisory Committee – an appointed seven member committee representing various interested parties, charged with administering the Perfusionist Licensure Act. The Committee would be granted the power and duty to do the following: adopt, amend or repeal rules as necessary to carry out the provisions of the Act; employ and compensate personnel they deem necessary to carry out the provisions of the Act; determine qualifications and fitness of applicants for licensure; issue, renew, deny, suspend or revoke licenses as authorized by the Act; set fees for licensure, renewal and other related services; establish continuing education requirements for licensees; establish a code of ethics; and maintain a current list of licensees.

The Committee would be able to grant reciprocity to persons licensed to practice perfusion in another state or territory of the United States with substantially equivalent standards of competency. The Committee could also grant a provisional license valid for up to 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee. Provisional licensees would be able to practice perfusion under the supervision and direction of a licensed perfusionist in accordance with rules adopted pursuant to the Act.

Qualifications for Licensure – applicants meeting the following qualifications would be licensed to practice perfusion: be at least 18 years old; complete an application; successfully complete an approved perfusion education program; pay the required fee; and be certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization.

Expenses and fees – fees payable to the Committee would be used to pay all expenses incurred in carrying out the purposes of the Act. The Committee would set the fees charged for applications, renewals, and related actions, not to exceed the amounts set forth in the Act.

Disciplinary Actions – the Committee would be empowered to deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if certain specified violations of sections of the Act are taken by a licensee or applicant. Civil penalties not to exceed $1,000 could be assessed for violation of sections of the Act or of any rules adopted by the Committee.

Third Party Reimbursement – nothing in the Act is to be construed to require third-party reimbursements to persons licensed under the Act.

Section 2 of the bill would direct the Committee to issue a license to practice perfusion to any person who has been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application or within five of the last eight years preceding application.

EFFECTIVE DATE: The provision establishing the North Carolina Perfusion Advisory Committee would become effective October 1, 2005. The remainder of the Act would become effective when it becomes law.

BACKGROUND: Perfusionists have been recognized as a definable health profession by the American Medical Association since 1977. Working under the direct supervision of a surgeon, perfusionists are the only non-licensed health care professionals who routinely administer drugs and blood products to patients. A perfusionist is the person responsible for the selection, set up, and operation of the heart-lung machine. To maintain life during open-heart surgery, the patient's heart must be stopped and the patient's blood is diverted outside the body, circulating through the heart-lung machine, and returned to the patient. Certification by the American Board of Cardiovascular Profusion (ABCP) is currently the accepted state and national standard for perfusionists.

The Legislative Committee on New Licensing Boards conducted an assessment of Senate Bill 1059 finding that the sponsors of the bill successfully met the criteria by which the Committee judges licensure proposals and recommending the licensure of perfusionists.

S1059e1-SMSS-CSSS

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 665*

Short Title:	County Medicaid Billing Systems.	(Public)
Sponsors:	Senators Hartsell; and Holloman.	
Referred to:	Health Care.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE PUBLIC HEALTH AUTHORITIES TO CONTRACT DIRECTLY WITH PRIVATE VENDORS TO OPERATE THE COUNTY BILLING SYSTEM FOR MEDICAID CLAIMS.

Whereas, the county share of the nonfederal share of Medicaid costs has a significant impact on county resources and cash flow; and

Whereas, more timely reimbursement of county Medicaid claims would improve county cash flow; and

Whereas, the current process for Medicaid billing is more complicated than necessary; and

Whereas, contracting with a private vendor to interface directly with the State Medicaid billing system would make the billing process for county Medicaid claims much simpler than it now is; and

Whereas, county public health authorities would benefit from private vendor-operated Medicaid billing by enabling the authorities to optimize revenue through efficiencies that are currently not in place through the State billing system; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 1B of Article 2 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-45.13. Authority to contract directly with private providers to operate billing system for county Medicaid claims.**

A public health authority board may contract directly with private vendors to operate the authority's Medicaid billing system as an alternative to the State-operated health services information system. The contract may provide for the private vendor to bill directly the State Medicaid billing system (MMIS), thereby bypassing the State health services information system (HSIS). The public health authority shall issue a "request for proposal" to solicit private vendor bids for contracts authorized under this section."

SECTION 2. This act is effective when it becomes law and applies to county Medicaid claims arising on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 665*
PROPOSED COMMITTEE SUBSTITUTE S665-PCS65312-SS-13

Short Title: Public Hlth Authorities/Co. Medicaid Billing. (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE PUBLIC HEALTH AUTHORITIES TO CONTRACT DIRECTLY WITH PRIVATE VENDORS TO OPERATE THE COUNTY BILLING SYSTEM FOR MEDICAID CLAIMS AND TO AUTHORIZE PUBLIC HEALTH AUTHORITIES TO INCREASE THEIR MEMBERSHIP.

Whereas, the county share of the nonfederal share of Medicaid costs has a significant impact on county resources and cash flow; and

Whereas, more timely reimbursement of county Medicaid claims would improve county cash flow; and

Whereas, the current process for Medicaid billing is more complicated than necessary; and

Whereas, contracting with a private vendor to interface directly with the State Medicaid billing system would make the billing process for county Medicaid claims much simpler than it now is; and

Whereas, county public health authorities would benefit from private vendor-operated Medicaid billing by enabling the authorities to optimize revenue through efficiencies that are currently not in place through the State billing system; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 1B of Article 2 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-45.13. Authority to contract directly with private providers to operate billing system for county Medicaid claims.**

A public health authority board may contract directly with private vendors to operate the authority's Medicaid billing system as an alternative to the State-operated health services information system. The contract may provide for the private vendor to bill directly the State Medicaid billing system (MMIS), thereby bypassing the State health

services information system (HSIS). The public health authority shall issue a "request for proposal" to solicit private vendor bids for contracts authorized under this section."

SECTION 2. G.S. 130A-45.1 reads as rewritten:

"**§ 130A-45.1. Membership of the public health authority board.**

(a) A public health authority board shall be the policy-making, rule-making, and adjudicatory body for a public health authority and shall be composed of no fewer than seven members and no more than nine members; except that in an authority comprising two or more counties, the board shall be composed of no more than 11 members. Boards which intend to pursue federally qualified health center (or look-alike) status may have no fewer than nine and no more than 25 members.

(b) In a single county authority, the county board of commissioners shall appoint the members of the board; in an authority comprising two or more counties, the chair of the county board of commissioners of each county in the authority shall appoint one county commissioner, or the commissioner's express designee, to the authority board and these members shall jointly appoint the other members of the board.

(c) The members of the board shall include:

(1) At least one physician licensed under Chapter 90 of the General Statutes to practice medicine in this State, and at least one dentist licensed under Article 2 of Chapter 90 of the General Statutes to practice dentistry in this State;

(2) At least one county commissioner or the commissioner's express designee from each county in the authority;

(3) At least two licensed or registered professionals from any of the following professions: optometry, veterinary science, nursing, pharmacy, engineering, or accounting;

(4) At least one member from the administrative staff of a hospital serving the authority service area; and

(5) At least one member from the general public.

(d) Except as provided in this subsection, members of the board shall serve terms of three years. ~~Two of the original members shall serve terms of one year, and two of the original members shall serve terms of two years.~~ In order to establish a uniform staggered term structure for the Board, a member may be appointed for less than a three-year term."

SECTION 3. This act is effective when it becomes law. Section 1 of this act applies to county Medicaid claims arising on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 665*
PROPOSED COMMITTEE SUBSTITUTE S665-CSSS-13 [v.3]

5/2/2005 12:33:16 PM

Short Title: Public Hlth Authorities/Co. Medicaid Billing. (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE PUBLIC HEALTH AUTHORITIES TO CONTRACT DIRECTLY WITH PRIVATE VENDORS TO OPERATE THE COUNTY BILLING SYSTEM FOR MEDICAID CLAIMS AND TO AUTHORIZE PUBLIC HEALTH AUTHORITIES TO INCREASE THEIR MEMBERSHIP.

Whereas, the county share of the nonfederal share of Medicaid costs has a significant impact on county resources and cash flow; and

Whereas, more timely reimbursement of county Medicaid claims would improve county cash flow; and

Whereas, the current process for Medicaid billing is more complicated than necessary; and

Whereas, contracting with a private vendor to interface directly with the State Medicaid billing system would make the billing process for county Medicaid claims much simpler than it now is; and

Whereas, county public health authorities would benefit from private vendor-operated Medicaid billing by enabling the authorities to optimize revenue through efficiencies that are currently not in place through the State billing system; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 1B of Article 2 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-45.13. Authority to contract directly with private providers to operate billing system for county Medicaid claims.**

A public health authority board may contract directly with private vendors to operate the authority's Medicaid billing system as an alternative to the State-operated health services information system. The contract may provide for the private vendor to bill directly the State Medicaid billing system (MMIS), thereby bypassing the State health

services information system (HSIS). The public health authority shall issue a "request for proposal" to solicit private vendor bids for contracts authorized under this section."

SECTION 2. G.S. 130A-45.1 reads as rewritten:

"**§ 130A-45.1. Membership of the public health authority board.**

(a) A public health authority board shall be the policy-making, rule-making, and adjudicatory body for a public health authority and shall be composed of no fewer than seven members and no more than nine members; except that in an authority comprising two or more counties, the board shall be composed of no more than 11 member. Boards which intend to pursue federally qualified health center (or look-alike) status may have no fewer than nine and no more than twenty-five members.

(b) In a single county authority, the county board of commissioners shall appoint the members of the board; in an authority comprising two or more counties, the chair of the county board of commissioners of each county in the authority shall appoint one county commissioner, or the commissioner's express designee, to the authority board and these members shall jointly appoint the other members of the board.

(c) The members of the board shall include:

(1) At least one physician licensed under Chapter 90 of the General Statutes to practice medicine in this State, and at least one dentist licensed under Article 2 of Chapter 90 of the General Statutes to practice dentistry in this State;

(2) At least one county commissioner or the commissioner's express designee from each county in the authority;

(3) At least two licensed or registered professionals from any of the following professions: optometry, veterinary science, nursing, pharmacy, engineering, or accounting;

(4) At least one member from the administrative staff of a hospital serving the authority service area; and

(5) At least one member from the general public.

(d) Except as provided in this subsection, members of the board shall serve terms of three years. ~~Two of the original members shall serve terms of one year, and two of the original members shall serve terms of two years.~~ In order to establish a uniform staggered term structure for the Board, a member may be appointed for less than a three-year term.

SECTION 3. This act is effective when it becomes law. Section 1 of this act applies to county Medicaid claims arising on or after that date.

SENATE BILL 665:
County Medicaid Billing Systems.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Hartsell
Date:	May 4, 2005	**Summary by:**	Ben Popkin
Version:	FS665-CSSS-13[v.3]		Committee Counsel

SUMMARY: ***Senate Bill 665 would authorize public health authority boards to contract directly with private vendors to operate the county billing system for Medicaid claims. The bill would be effective when it becomes law and would apply to county Medicaid claims arising on or after that date.***

The Proposed Committee Substitute would include a section allowing for the expansion of public health authority boards for boards intending to pursue federally qualified health center (or look alike) status.

CURRENT LAW: **Section 1** – Current DHHS policy requires local health departments, including those operated by public health authority boards, to report and bill through the State Health Services Information System (HSIS). Private providers may bill the State Medicaid billing system (MMIS) directly, through DMA-supplied software.

Section 2 – Section 1905 of the Social Security Act creates a category of facility under Medicaid and Medicare known as Federally Qualified Health Centers (FQHCs). The Social Security Act § 1905(l)(2))B) definition of an FQHC includes an entity which is determined to meet the requirements of the section 330 grant program but does not receive the grant. This category of health centers has been labeled FQHC Look-Alikes. The FQHC Look-Alikes receive no section 330 Federal funding but are eligible for cost-based reimbursement under Medicaid and Medicare and participate in the 340(b) Federal Drug Pricing program.

Applicants for FQHC Look-Alike designation must be fully operational at application date and meet the following requirements:

1. Be a public or a private nonprofit entity;
2. Serve, in whole or in part, a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP);
3. Meet the statutory, regulatory and policy requirements for grantees supported under section 330 (formerly 329, 330 and 340) of Public Health Service Act; and
4. Comply with the policy implementation documents for the Balanced Budget Act (BBA) of 1997 amendment which added the requirement that an FQHC Look-Alike entity may not be owned, controlled or operated by another entity.

Designation as FQHC or FQHC look-alike brings the following benefits: Section 330 Federal funding (for FQHCs); pharmaceutical benefits through participation in the 340(b) Federal Drug Pricing program; and cost-based reimbursement under Medicaid and Medicare. States are required to pay current FQHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services. The FQHC covered core services include services provided by physicians, physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, clinical social workers, and services and supplies incident

to those services. Any other ambulatory service included in a State's Medicaid plan is considered a covered service under the FQHC benefit, if the FQHC offers such a service and meets applicable requirements for a provider of that service

BILL ANALYSIS: **Section 1** – This bill would allow public health authority boards to contract with private vendors to operate their Medicaid billing system – a power previously restricted to only private providers, not public providers like the local health departments. Contracts entered into by the boards could allow for the private vendors to bill MMIS directly, rather than going through the HSIS, as is now the case for public providers. The bill sets forth the process by which the public health authority boards may contract with private vendors – they must issue a "request for proposal" to solicit private vendor bids for contracts.

Section 2 – The bill would raise the public health authority board membership from a range of 7 to 9 members (or 11 maximum if serving 2 or more counties) to a range of 9 to 25 members. This shift would be done in order to assist boards in satisfying the governance requirements (point number 4, below) for designation as FQHC or FQHC look-alike.

BACKGROUND: **Section 1** – A public health authority may be created "...upon joint resolution of the county board of commissioner and the local board of health...to provide public health services as required under G.S. 130A-34."[1] To date, two public health authority boards have been formed – Cabarrus Health Alliance (Concord) and Hertford County Health Authority (Winton).

Section 2 – FQHC Look-Alikes are a Bureau of Primary Health Care/ Health Resources and Services Administration program intended to strengthen the safety net for populations at risk. The program has grown from the initial 28 designations in 1991 to the current 111 designated health centers, with 182 sites, providing primary care services to over 1,120,000 users. Approximately 40 FQHC Look-Alikes have competed for and been approved for Section 330 funding.

There are four basic program requirements that must be satisfied for a health center to be designated as an FQHC of FQHC Look-Alike:

1. **Need and Community Impact:** Applicant must demonstrate the need for primary health care services in the community(ies) that make up its service area by documenting the lack of sufficient health care resources in the service area to meet the primary health care needs of the target population.

2. **Health Services:** Applicants must have a system of care that contributes to the availability, accessibility, quality, comprehensiveness and coordination of health services in the service area.

3. **Management and Finance:** Applicants must have a management team that is supported by strong personnel, financial, information and clinical systems.

4. **Governance:** Applicants must be governed by a Board of Directors which is representative of the community and users being served and which has full authority and responsibility.

S665-CSSS-001[v.3]

[1] G.S. 130A-45.02(a)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 780

Committee Substitute Favorable 4/12/05

Short Title: Need-Based Nursing Scholarships.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE PROCESS BY WHICH THE NEED-BASED SCHOLARSHIP LOAN FUND IS ADMINISTERED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.65 reads as rewritten:

"**§ 90-171.65. Need-based nursing scholarships fund.**

(a) There is created a need-based scholarship loan fund for nursing students. Need-based scholarship loans shall be available for study in nursing programs offered by community colleges and The University of North Carolina, and by private colleges ~~which~~ that offer licensed practical nursing or registered nursing programs. Part-time students and nontraditional students who have post-secondary degrees, and registered nurses pursuing a baccalaureate degree in nursing, are eligible to receive need-based nursing scholarship loans.

(b) Need-based nursing scholarship loan funds shall be administered by the ~~State Board of Community Colleges, the Board of Governors of The University of North Carolina, and the State Education Assistance Authority. The State Board of Community Colleges and the Board of Governors of The University of North Carolina shall allocate the scholarship loan funds among their respective constituent institutions which have programs of education leading to a degree in nursing. Distribution shall be in a manner determined by the appropriate governing body. The State Education Assistance Authority shall distribute scholarship loan funds to private nonprofit colleges which offer nursing degree programs. Distribution shall be in a manner determined by the Board of the State Education Assistance Authority after consultation with the North Carolina Association of Independent Colleges and Universities.~~State Education Assistance Authority in accordance with rules and regulations adopted by the Board of the State Education Assistance Authority. Distribution of scholarship loan funds among students enrolled in the constituent institutions of The University of North Carolina, community colleges, and private colleges shall be in amounts proportionate to the amounts awarded to each such group of students in the preceding fiscal year.

Scholarship loans shall be made only to prospective and enrolled nursing students under the terms and conditions established for the need-based nursing scholarship loan program by the State Education Assistance Authority.

(c) The State Education Assistance Authority shall carry out the following functions in implementing the need-based nursing scholarship loan program:

(1) Promulgate the rules and regulations necessary to implement the scholarship ~~program;~~program, including the selection criteria and method of selection of recipients of need-based nursing scholarship loans;

(2) Disburse, collect, and monitor scholarship loan funds;

(3) Establish the terms and conditions of promissory notes executed by loan recipients;

(4) Approve service repayment agreements;

(5) Collect cash repayments required when service repayment is not completed; and

(6) Adopt rules to allow for the forgiveness of scholarship loans if it determines that it is impossible for the recipient to practice nursing in North Carolina for a sufficient time to repay the loan because of the death or permanent disability of the recipient within ten years following graduation or termination of enrollment in a nursing education program.

~~(d) Each institution to which scholarship loan funds are allocated shall publicize the availability of, shall disseminate, receive and review applications for, and shall select the recipients of scholarship loans. Scholarship loans shall be made only to prospective and enrolled nursing students under the terms and conditions established for the need-based nursing scholarship loan program by the State Education Assistance Authority.~~"

SECTION 2. This act becomes effective January 1, 2006, and applies to all scholarship loans awarded after that date.

HOUSE BILL 780:
Need-Based Nursing Scholarships.-AB.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Rep. Yongue
Date:	May 4, 2005	**Summary by:**	Shawn Parker
Version:	H780-2nd edition		Committee Staff

SUMMARY: ***The Second Edition of House Bill 780 amends the need-based Nurse Education Scholarship Loan Program so that the State Education Assistance Authority administers the program in the same manner as other need-based scholarships. The bill gives the State Education Assistance Authority the responsibility for adopting rules for selecting candidates to receive the scholarship loans. The bill also makes technical and conforming changes. The act becomes effective January 1, 2006 and applies to all scholarship loans awarded after that date.***

CURRENT LAW: The General Assembly created a need-based scholarship loan fund for students in licensed practical nursing or registered nursing programs offered by community colleges, UNC constituent institutions and private colleges.

The need-based nursing scholarship loan funds shall be administered by the State Board of Community Colleges, the UNC Board of Governors, and the State Education Assistance Authority. The State Board of Community Colleges and the UNC Board of Governors shall determine how the funds are allocated among their respective constituent institutions. After consulting with the N.C. Association of Independent Colleges and Universities, the Board of the State Education Assistance Authority shall determine how funds are allocated to private nonprofit colleges offering nursing degrees.

Each institution receiving funds is responsible for publicizing the availability of the scholarship loans, distributing and reviewing applications for the scholarship loans and selecting recipients.

BILL ANALYSIS: The State Education Assistance Authority assumes responsibility for administering the need-based nursing scholarship loan funds in accordance with rules adopted by its board.

Distribution of the scholarship loan funds to students enrolled in the community colleges, UNC constituent institutions, and private colleges shall be proportional to the amounts awarded to the same category of students in the previous fiscal year.

The State Education Assistance Authority assumes responsibility for promulgating rules necessary to implement the program, including the selection criteria and method of selecting recipients.

BACKGROUND: The 1989 General Assembly first funded the program as part of an effort to reduce the shortage of practicing nurses in the State. The awards for the Nurse Education Scholarship Loan Program range from $400 to $5,000. The maximum amount for students enrolled in associate nursing degree and LPN programs is $3,000. The maximum amount for students enrolled in a BSN program is $5,000. The loan is forgiven if the student works one year for each year that the loan was received. Loans that are not repaid through service must be repaid in cash.

The UNC Board of Governors requested this bill as a part of its 2005 non-budget legislative initiatives.

H780-SMSQ-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 277*

Committee Substitute Favorable 3/30/05

Short Title: Establish Child Assessment Responses. (Public)

Sponsors:

Referred to:

February 17, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR FAMILY ASSESSMENT RESPONSES IN CASES IN WHICH CHILDREN ARE REPORTED TO BE NEGLECTED OR DEPENDENT AND FOR INVESTIGATIVE ASSESSMENT RESPONSES IN CASES IN WHICH CHILDREN ARE REPORTED TO BE ABUSED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-101 reads as rewritten:

"**§ 7B-101. Definitions.**

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

(1) Abused juveniles. – Any juvenile less than 18 years of age whose parent, guardian, custodian, or caretaker:

a. Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means;

b. Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means;

c. Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;

d. Commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile: first-degree rape, as provided in G.S. 14-27.2; second degree rape as provided in G.S. 14-27.3; first-degree sexual offense, as provided in G.S. 14-27.4; second degree sexual offense, as provided in G.S. 14-27.5; sexual act by a custodian, as provided in G.S. 14-27.7; crime against nature, as provided in G.S. 14-177; incest, as provided in ~~G.S. 14-178 and G.S. 14-179;~~ G.S. 14-178; preparation of obscene photographs, slides, or motion pictures of the juvenile, as provided in

G.S. 14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in G.S. 14-190.6; dissemination of obscene material to the juvenile as provided in G.S. 14-190.7 and G.S. 14-190.8; displaying or disseminating material harmful to the juvenile as provided in G.S. 14-190.14 and G.S. 14-190.15; first and second degree sexual exploitation of the juvenile as provided in G.S. 14-190.16 and G.S. 14-190.17; promoting the prostitution of the juvenile as provided in G.S. 14-190.18; and taking indecent liberties with the juvenile, as provided in ~~G.S. 14-202.1, regardless of the age of the parties;~~ G.S. 14-202.1;

e. Creates or allows to be created serious emotional damage to the juvenile; serious emotional damage is evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others; or

f. Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile.

(2) Aggravated circumstances. – Any circumstance attending to the commission of an act of abuse or neglect which increases its enormity or adds to its injurious consequences, including, but not limited to, abandonment, torture, chronic abuse, or sexual abuse.

(3) Caretaker. – Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent, foster parent, an adult member of the juvenile's household, an adult relative entrusted with the juvenile's care, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services. "Caretaker" also means any person who has the responsibility for the care of a juvenile in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes and includes any person who has the approval of the care provider to assume responsibility for the juveniles under the care of the care provider. Nothing in this subdivision shall be construed to impose a legal duty of support under Chapter 50 or Chapter 110 of the General Statutes. The duty imposed upon a caretaker as defined in this subdivision shall be for the purpose of this Subchapter only.

(4) Clerk. – Any clerk of superior court, acting clerk, or assistant or deputy clerk.

(5) Community-based program. – A program providing nonresidential or residential treatment to a juvenile in the community where the juvenile's family lives. A community-based program may include

specialized foster care, family counseling, shelter care, and other appropriate treatment.

(6) Court. – The district court division of the General Court of Justice.

(7) Court of competent jurisdiction. – A court having the power and authority of law to act at the time of acting over the subject matter of the cause.

(7a) ~~"Criminal history" means a~~Criminal history. – A local, State, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or a felony, involving violence against a person.

(8) Custodian. – The person or agency that has been awarded legal custody of a juvenile by a court or a person, other than parents or legal guardian, who has assumed the status and obligation of a parent without being awarded the legal custody of a juvenile by a court.

(9) Dependent juvenile. – A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or whose parent, guardian, or custodian is unable to provide for the care or supervision and lacks an appropriate alternative child care arrangement.

(10) Director. – The director of the county department of social services in the county in which the juvenile resides or is found, or the director's representative as authorized in G.S. 108A-14.

(11) District. – Any district court district as established by G.S. 7A-133.

(11a) Family assessment response. – A response to selected reports of child neglect and dependency as determined by the Director using a family-centered approach that is protection and prevention oriented and that evaluates the strengths and needs of the juvenile's family, as well as the condition of the juvenile.

(11b) Investigative assessment response. – A response to reports of child abuse and selected reports of child neglect and dependency as determined by the Director using a formal information gathering process to determine whether a juvenile is abused, neglected, or dependent.

(12) Judge. – Any district court judge.

(13) Judicial district. – Any district court district as established by G.S. 7A-133.

(14) Juvenile. – A person who has not reached the person's eighteenth birthday and is not married, emancipated, or a member of the armed forces of the United States.

(15) Neglected juvenile. – A juvenile who does not receive proper care, supervision, or discipline from the juvenile's parent, guardian, custodian, or caretaker; or who has been abandoned; or who is not provided necessary medical care; or who is not provided necessary remedial care; or who lives in an environment injurious to the

juvenile's welfare; or who has been placed for care or adoption in violation of law. In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died as a result of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse or neglect by an adult who regularly lives in the home.

(16) Petitioner. – The individual who initiates court action, whether by the filing of a petition or of a motion for review alleging the matter for adjudication.

(17) Prosecutor. – The district attorney or assistant district attorney assigned by the district attorney to juvenile proceedings.

(18) Reasonable efforts. – The diligent use of preventive or reunification services by a department of social services when a juvenile's remaining at home or returning home is consistent with achieving a safe, permanent home for the juvenile within a reasonable period of time. If a court of competent jurisdiction determines that the juvenile is not to be returned home, then reasonable efforts means the diligent and timely use of permanency planning services by a department of social services to develop and implement a permanent plan for the juvenile.

(19) Safe home. – A home in which the juvenile is not at substantial risk of physical or emotional abuse or neglect.

(20) Shelter care. – The temporary care of a juvenile in a physically unrestricting facility pending court disposition.

The singular includes the plural, the masculine singular includes the feminine singular and masculine and feminine plural unless otherwise specified."

SECTION 2. G.S. 7B-300 reads as rewritten:

"**§ 7B-300. Protective services.**

The director of the department of social services in each county of the State shall establish protective services for juveniles alleged to be abused, neglected, or dependent.

Protective services shall include the ~~investigation and~~ screening of ~~complaints,~~ reports, the performance of an assessment using either a family assessment response or an investigative assessment response, casework, or other counseling services to parents, guardians, or other caretakers as provided by the director to help the parents, guardians, or other caretakers and the court to prevent abuse or neglect, to improve the quality of child care, to be more adequate parents, guardians, or caretakers, and to preserve and stabilize family life.

The provisions of this Article shall also apply to child care facilities as defined in G.S. 110-86."

SECTION 3. G.S. 7B-301 reads as rewritten:

"**§ 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.**

Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of

social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the department's ~~investigation~~ assessment of the alleged abuse, neglect, dependency, or death as a result of maltreatment.

Upon receipt of any report of sexual abuse of the juvenile in a child care facility, the director shall notify the State Bureau of Investigation within 24 hours or on the next workday. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the ~~investigation~~ assessment there is reason to suspect that sexual abuse has occurred, the director shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report."

SECTION 4. G.S. 7B-302 reads as rewritten:

"**§ 7B-302. ~~Investigation~~ Assessment by director; access to confidential information; notification of person making the report.**

(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough ~~investigation~~ assessment, using either a family assessment response or an investigative assessment response, in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the ~~investigation.~~ assessment. When the report alleges neglect or dependency, the director shall initiate the ~~investigation~~ assessment within 72 hours following receipt of the report. When the report alleges abandonment, the director shall immediately initiate an ~~investigation,~~ assessment, take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The ~~investigation~~ assessment and evaluation shall include a visit to the place where the juvenile ~~resides.~~resides, except when the report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes. When a report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes, a visit to the place where the juvenile resides is not required. When the report alleges abandonment, the ~~investigation~~ assessment shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national

and State resources whether the juvenile is a missing child. All information received by the department of social services, including the identity of the reporter, shall be held in strictest confidence by the department.

(b) When a report of a juvenile's death as a result of suspected maltreatment or a report of suspected abuse, neglect, or dependency of a juvenile in a noninstitutional setting is received, the director of the department of social services shall immediately ascertain if other juveniles live in the home, and, if so, initiate an ~~investigation~~ assessment in order to determine whether they require protective services or whether immediate removal of the juveniles from the home is necessary for their protection. When a report of a juvenile's death as a result of maltreatment or a report of suspected abuse, neglect, or dependency of a juvenile in an institutional setting such as a residential child care facility or residential educational facility is received, the director of the department of social services shall immediately ascertain if other juveniles remain in the facility subject to the alleged perpetrator's care or supervision, and, if so, assess the circumstances of those juveniles in order to determine whether they require protective services or whether immediate removal of those juveniles from the facility is necessary for their protection.

(c) If the ~~investigation~~ assessment indicates that abuse, neglect, or dependency has occurred, the director shall decide whether immediate removal of the juvenile or any other juveniles in the home is necessary for their protection. If immediate removal does not seem necessary, the director shall immediately provide or arrange for protective services. If the parent, guardian, custodian, or caretaker refuses to accept the protective services provided or arranged by the director, the director shall sign a complaint seeking to invoke the jurisdiction of the court for the protection of the juvenile or juveniles.

(d) If immediate removal seems necessary for the protection of the juvenile or other juveniles in the home, the director shall sign a complaint ~~which~~ that alleges the applicable facts to invoke the jurisdiction of the court. Where the ~~investigation~~ assessment shows that it is warranted, a protective services worker may assume temporary custody of the juvenile for the juvenile's protection pursuant to Article 5 of this Chapter.

(d1) Whenever a juvenile is removed from the home of a parent, guardian, custodian, stepparent, or adult relative entrusted with the juvenile's care due to physical abuse, the director shall conduct a thorough review of the background of the alleged abuser or abusers. This review shall include a criminal history check and a review of any available mental health records. If the review reveals that the alleged abuser or abusers have a history of violent behavior against people, the director shall petition the court to order the alleged abuser or abusers to submit to a complete mental health evaluation by a licensed psychologist or psychiatrist.

(e) In performing any duties related to the ~~investigation~~ assessment of the ~~complaint~~ report or the provision or arrangement for protective services, the director may consult with any public or private agencies or individuals, including the available State or local law enforcement officers who shall assist in the ~~investigation~~ assessment and evaluation of the seriousness of any report of abuse, neglect, or dependency when requested by the director. The director or the director's representative may make a

written demand for any information or reports, whether or not confidential, that may in the director's opinion be relevant to the ~~investigation of or the provision for~~ assessment or provision of protective services. Upon the director's or the director's representative's request and unless protected by the attorney-client privilege, any public or private agency or individual shall provide access to and copies of this confidential information and these records to the extent permitted by federal law and regulations. If a custodian of criminal investigative information or records believes that release of the information will jeopardize the right of the State to prosecute a defendant or the right of a defendant to receive a fair trial or will undermine an ongoing or future investigation, it may seek an order from a court of competent jurisdiction to prevent disclosure of the information. In such an action, the custodian of the records shall have the burden of showing by a preponderance of the evidence that disclosure of the information in question will jeopardize the right of the State to prosecute a defendant or the right of a defendant to receive a fair trial or will undermine an ongoing or future investigation. Actions brought pursuant to this paragraph shall be set down for immediate hearing, and subsequent proceedings in the actions shall be accorded priority by the trial and appellate courts.

(f) Within five working days after receipt of the report of abuse, neglect, or dependency, the director shall give written notice to the person making the report, unless requested by that person not to give notice, as to whether the report was accepted for ~~investigation~~ assessment and whether the report was referred to the appropriate State or local law enforcement agency.

(g) Within five working days after completion of the protective services ~~investigation,~~ assessment, the director shall give subsequent written notice to the person making the report, unless requested by that person not to give notice, as to whether there is a finding of abuse, neglect, or dependency, whether the county department of social services is taking action to protect the juvenile, and what action it is taking, including whether or not a petition was filed. The person making the report shall be informed of procedures necessary to request a review by the prosecutor of the director's decision not to file a petition. A request for review by the prosecutor shall be made within five working days of receipt of the second notification. The second notification shall include notice that, if the person making the report is not satisfied with the director's decision, the person may request review of the decision by the prosecutor within five working days of receipt. The person making the report may waive the person's right to this notification, and no notification is required if the person making the report does not identify himself to the director.

(h) The director or the director's representative may not enter a private residence for ~~investigation~~ assessment purposes without at least one of the following:

(1) The reasonable belief that a juvenile is in imminent danger of death or serious physical injury.

(2) The permission of the parent or person responsible for the juvenile's care.

(3) The accompaniment of a law enforcement officer who has legal authority to enter the residence.

(4) An order from a court of competent jurisdiction."

SECTION 5. G.S. 7B-303 reads as rewritten:

"**§ 7B-303. Interference with ~~investigation.~~ assessment.**

(a) If any person obstructs or interferes with an ~~investigation~~ assessment required by G.S. 7B-302, the director may file a petition naming ~~said~~ that person as respondent and requesting an order directing the respondent to cease ~~such~~ the obstruction or interference. The petition shall contain the name and date of birth and address of the juvenile who is the subject of the ~~investigation,~~ assessment; shall include a concise statement of the basis for initiating the assessment, shall specifically describe the conduct alleged to constitute obstruction of or interference with the ~~investigation,~~ assessment; and shall be verified.

(b) For purposes of this section, obstruction of or interference with an ~~investigation~~ assessment means refusing to disclose the whereabouts of the juvenile, refusing to allow the director to have personal access to the juvenile, refusing to allow the director to observe or interview the juvenile in private, refusing to allow the director access to confidential information and records upon request pursuant to G.S. 7B-302, refusing to allow the director to arrange for an evaluation of the juvenile by a physician or other expert, or other conduct that makes it impossible for the director to carry out the duty to ~~investigate.~~ assess the juvenile's condition.

(c) Upon filing of the petition, the court shall schedule a hearing to be held not less than five days after service of the petition and summons on the respondent. Service of the petition and summons and notice of hearing shall be made as provided by the Rules of Civil Procedure on the respondent; the juvenile's parent, guardian, custodian, or caretaker; and any other person determined by the court to be a necessary party. If at the hearing on the petition the court finds by clear, cogent, and convincing evidence that the respondent, without lawful excuse, has obstructed or interfered with an ~~investigation~~ assessment required by G.S. 7B-302, the court may order the respondent to cease such obstruction or interference. The burden of proof shall be on the petitioner.

(d) If the director has reason to believe that the juvenile is in need of immediate protection or assistance, the director shall so allege in the petition and may seek an ex parte order from the court. If the court, from the verified petition and any inquiry the court makes of the director, finds probable cause to believe both that the juvenile is at risk of immediate harm and that the respondent is obstructing or interfering with the director's ability to ~~investigate to determine~~ assess the juvenile's condition, the court may enter an ex parte order directing the respondent to cease ~~such~~ the obstruction or interference. The order shall be limited to provisions necessary to enable the director to conduct an ~~investigation~~ assessment sufficient to determine whether the juvenile is in need of immediate protection or assistance. Within 10 days after the entry of an ex parte order under this subsection, a hearing shall be held to determine whether there is good cause for the continuation of the order or the entry of a different order. An order entered under this subsection shall be served on the respondent along with a copy of the petition, summons, and notice of hearing.

(e) The director may be required at a hearing under this section to reveal the identity of any person who made a report of suspected abuse, neglect, or dependency as required by G.S. 7B-301.

(f) An order entered pursuant to this section is enforceable by civil or criminal contempt as provided in Chapter 5A of the General Statutes."

SECTION 6. G.S. 7B-305 reads as rewritten:

"**§ 7B-305. Request for review by prosecutor.**

The person making the report shall have five working days, from receipt of the decision of the director of the department of social services not to petition the court, to notify the prosecutor that the person is requesting a review. The prosecutor shall notify the person making the report and the director of the time and place for the review, and the director shall immediately transmit to the prosecutor a copy of ~~the investigation report.~~ a summary of the assessment."

SECTION 7. G.S. 7B-307 reads as rewritten:

"**§ 7B-307. Duty of director to report evidence of abuse, neglect; investigation by local law enforcement; notification of Department of Health and Human Services and State Bureau of Investigation.**

(a) If the director finds evidence that a juvenile may have been abused as defined by G.S. 7B-101, the director shall make an immediate oral and subsequent written report of the findings to the district attorney or the district attorney's designee and the appropriate local law enforcement agency within 48 hours after receipt of the report. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate and coordinate a criminal investigation with the protective services ~~investigation~~ assessment being conducted by the county department of social services. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate and may request the director or the director's designee to appear before a magistrate.

If the director receives information that a juvenile may have been physically harmed in violation of any criminal statute by any person other than the juvenile's parent, guardian, custodian, or caretaker, the director shall make an immediate oral and subsequent written report of that information to the district attorney or the district attorney's designee and to the appropriate local law enforcement agency within 48 hours after receipt of the information. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate a criminal investigation. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate.

If the report received pursuant to G.S. 7B-301 involves abuse or neglect of a juvenile in child care, the director shall notify the Department of Health and Human Services within 24 hours or on the next working day of receipt of the report.

(b) If the director finds evidence that a juvenile has been abused or neglected as defined by G.S. 7B-101 in a child care facility, the director shall immediately so notify the Department of Health and Human Services and, in the case of sexual abuse, the State Bureau of Investigation, in such a way as does not violate the law guaranteeing the confidentiality of the records of the department of social services.

(c) Upon completion of the ~~investigation,~~ assessment, the director shall give the Department written notification of the results of the ~~investigation~~ assessment required by G.S. 7B-302. Upon completion of an ~~investigation~~ assessment of sexual abuse in a

child care facility, the director shall also make written notification of the results of the ~~investigation~~ assessment to the State Bureau of Investigation.

The director of the department of social services shall submit a report of alleged abuse, neglect, or dependency cases or child fatalities that are the result of alleged maltreatment to the central registry under the policies adopted by the Social Services Commission."

SECTION 8. G.S. 7B-308(b) reads as rewritten:

"(b) Immediately upon receipt of judicial authority to retain custody, the physician, the administrator, or that person's designee shall so notify the director of social services for the county in which the facility is located. The director shall treat this notification as a report of suspected abuse and shall immediately begin an ~~investigation~~ assessment of the case.

(1) If the ~~investigation~~ assessment reveals (i) that it is the opinion of the certifying physician that the juvenile is in need of medical treatment to cure or alleviate physical distress or to prevent the juvenile from suffering serious physical injury, and (ii) that it is the opinion of the physician that the juvenile should for these reasons remain in the custody of the facility for 12 hours, but (iii) that the juvenile's parent, guardian, custodian, or caretaker cannot be reached or, upon request, will not consent to the treatment within the facility, the director shall within the initial 12-hour period file a juvenile petition alleging abuse and setting forth supporting allegations and shall seek a nonsecure custody order. A petition filed and a nonsecure custody order obtained in accordance with this subdivision shall come on for hearing under the regular provisions of this Subchapter unless the director and the certifying physician together voluntarily dismiss the petition.

(2) In all cases except those described in subdivision (1) above, the director shall conduct the ~~investigation~~ assessment and may initiate juvenile proceedings and take all other steps authorized by the regular provisions of this Subchapter. If the director decides not to file a petition, the physician, the administrator, or that person's designee may ask the prosecutor to review this decision according to the provisions of G.S. 7B-305 and G.S. 7B-306."

SECTION 9. G.S. 7B-309 reads as rewritten:

"**§ 7B-309. Immunity of persons reporting and cooperating in an ~~investigation.~~ assessment.**

Anyone who makes a report pursuant to this Article, cooperates with the county department of social services in a protective services ~~inquiry or investigation,~~ assessment, testifies in any judicial proceeding resulting from a protective services report or ~~investigation,~~ assessment, or otherwise participates in the program authorized by this Article, is immune from any civil or criminal liability that might otherwise be incurred or imposed for that action provided that the person was acting in good faith. In any proceeding involving liability, good faith is presumed."

SECTION 10. G.S. 7B-404(a) reads as rewritten:

"(a) When the office of the clerk is closed, a magistrate may be authorized by the chief district court judge to draw, verify, and issue petitions as follows:

(1) When the director of the department of social services requests a petition alleging a juvenile to be abused, neglected, or dependent, or

(2) When the director of the department of social services requests a petition alleging the obstruction of or interference with an ~~investigation~~ assessment required by G.S. 7B-302."

SECTION 11. G.S. 7B-506(h)(3) reads as rewritten:

"(3) Inquire as to whether there are other juveniles remaining in the home from which the juvenile was removed and, if there are, inquire as to the specific findings of the ~~investigation~~ assessment conducted under G.S. 7B-302 and any actions taken or services provided by the director for the protection of the other juveniles."

SECTION 12. G.S. 108A-14(a)(11) reads as rewritten:

"**§ 108A-14. Duties and responsibilities.**

(a) The director of social services shall have the following duties and responsibilities:

...

(11) To ~~investigate~~ assess reports of child abuse and neglect and to take appropriate action to protect such children pursuant to the Child Abuse Reporting Law, Article 3 of Chapter 7B of the General Statutes;".

SECTION 13. The Department of Health and Human Services shall continue to assess the alternative response system of child protection as to the impact the system has in child safety, timeliness of response, timeliness of service, and coordination of local human services. The Department shall report the status of its evaluation to the Legislative Study Commission on Children and Youth, 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 before the convening of the 2006 Regular Session of the 2005 General Assembly.

SECTION 14. This act becomes effective October 1, 2005.

HOUSE BILL 277:
Establish Child Assessment Responses

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Reps. Glazier, Alexander, and Carney
Date:	May 4, 2005		
Version:	H277 2nd edition	**Summary by:**	Shawn Parker Committee Staff

SUMMARY: ***House Bill 277 would authorize counties to utilize an alternative response system (known as the Multiple Response System, or MRS) to assess reports of child abuse, neglect, and abandonment, currently being piloted in 52 counties, and would require a continued assessment of MRS. The bill would permit local departments of social services to determine whether to visit the home of a juvenile if a report involves alleged abuse or neglect in a child care facility, and would codify language from case law to require a statement of the basis for initiating an assessment of a report of abuse or neglect in an interference petition. The act would become effective October 1, 2005.***

CURRENT LAW AND BACKGROUND: Local departments of social services (DSS) are responsible for establishing child protective services to investigate and screen reports of child abuse, neglect, and abandonment. When a report of abuse, neglect, or dependency is received, the director of the local DSS is required to initiate an investigation to ascertain the facts, the extent of the abuse or neglect, and the risk of harm in order to determine whether protective services should be provided. If any person obstructs or interferes with an investigation, DSS may petition the court for an order directing the person to cease with the obstruction or interference. If the director of DSS finds evidence that a child has been abused, neglected, or abandoned, the director may commence a civil action in juvenile court.

In 2001, the General Assembly authorized the Department of Health and Human Services (DHHS) to develop a plan, working with local DSS, to implement an alternative response system of child protection in no fewer than two and no more than 10 demonstration areas. The legislation required DHHS to develop data collection processes to enable the General Assembly to assess the impact of these pilots. In 2003, this pilot program was expanded. Currently, 52 counties utilize this alternative system, known as the Multiple Response System (MRS).[1]

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[1] According to the State's Division of Social Services, MRS utilizes seven strategies for providing child protective services:

- A strengths-based, structured intake process, utilizing objective, structured intake tools and consistent screening criteria to identify abuse, neglect, and dependency, and includes an assessment of the family's strengths.
- A choice of two approaches to reports of abuse, neglect, or dependency, allowing social workers to distinguish between cases of child neglect and dependency and those of abuse.
- Coordination between law enforcement agencies and child protective services.
- A redesign of in-home services to provide families with the greatest needs with the most intensive services and contacts while families with fewer needs are provided with less intensive assistance.
- Child and Family Team meetings to allow families to be involved with social services staff in making decisions about ways to improve the lives of the family's children.
- Implementation of Shared-Parenting meetings in child placement cases to allow the social worker, birthparents, and foster parents to meet and discuss the care of the child when out-of-home placement is necessary.
- Collaboration between Work First Family Assistance and child welfare programs.

In MRS pilot counties, when a report of abuse, neglect, or abandonment is received, depending upon the nature of the report, DSS performs an assessment using either a family assessment response or an investigative assessment response. When abuse is alleged, and in some cases of neglect or abandonment, MRS pilot counties utilize a formal information gathering process, much like a traditional investigation that non-MRS counties undertake upon the receipt of any report. In other cases, MRS counties assess reports utilizing a family assessment response, which is less formal and evaluates the strengths and needs of the juvenile's family.

Duke University's Center for Child and Family Policy has been evaluating MRS, submitted a report to the General Assembly on April 1, 2004, and is expected to submit a second report in June. In its April 2004 report, the Center made the following recommendations based upon the findings of the report and feedback received through the focus groups in the nine counties visited:

1. Limit caseload size to 6 –8 families per worker or implement a "team model" with teams consisting of investigators/assessors, case managers, and foster care workers that act as a cohesive unit to serve a family.
2. Implement additional and consistent training for line staff.
3. Implement supervisory and management training immediately.
4. Appropriate state dollars to conduct cross-agency family-centered training for all child-serving agencies.
5. Create a new decision category to address those instances when families receive services during assessment period and do not need additional supervision beyond this time, called "services received, no further services recommended."
6. Conduct a more systematic and detailed evaluation when MRS has been in practice for a longer period of time.
7. Evaluate the next wave of implementation immediately.

BILL ANALYSIS: House Bill 277 would amend the juvenile law to permit all counties to utilize the MRS approach to assessing reports of child abuse, neglect, and abandonment.

Section 1 would add the definitions of "family assessment response" and "investigative assessment response". The section would also delete an outdated statutory reference and would apply the ages of the parties in the indecent liberties statute in determining whether abuse may have occurred.

Section 2 would amend current law to specify that protective services would include the performance of either a family assessment response or an investigative response.

Sections 3 through 12 would make conforming changes to the juvenile code, specifically by changing the word "investigation" to "assessment" where applicable.

Section 4 would permit DSS to determine whether a visit to the place where the juvenile resides is necessary when the report alleges abuse or neglect in a child-care facility.

Section 5 would amend the law concerning interference with an investigation to require DSS to include in a petition a concise statement of the basis for initiating the assessment. This is consistent with the North Carolina Supreme court's opinion in In re Stumbo, 357 N.C. 279 (2003), where the court held that "before any investigation is initiated or interference with any such investigation ensues, the proper inquiry that must be made by DSS is whether an investigation is mandated based upon the first report or multiple reports that show a pattern of neglect."

Section 13 would require the Department of Health and Human Services to continue to assess MRS and report the status of its evaluation to the Legislative Study Commission on Children and Youth, the HHS appropriations subcommittees and Fiscal Research prior to the convening of the short session.

Dianna Jessup contributed significantly to this summary.

H277-SMSQ-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 804

Short Title: Public Health Task Force/Accred. Recommend. (Public)

Sponsors: Senator Hartsell.

Referred to: Education/Higher Education.

March 23, 2005

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE PUBLIC HEALTH INFRASTRUCTURE BY ESTABLISHING AN ACCREDITATION SYSTEM FOR LOCAL HEALTH DEPARTMENTS, AS RECOMMENDED BY THE PUBLIC HEALTH TASK FORCE 2004, AND TO APPROPRIATE FUNDS TO IMPLEMENT THIS ACT.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 130A-2 is amended by adding the following new subdivision in alphabetical order to read:

"**§ 130A-2. Definitions.**

The following definition shall apply throughout this Chapter unless otherwise specified:

...

(01) "Accreditation board" or "Board" means the Local Health Department Accreditation Board."

SECTION 1.(b) Part 1 of Article 2 of Chapter 130A of the General Statutes is amended by adding a new section to read:

"**§ 130A-34.1. Accreditation of local health departments; board established.**

(a) The Local Health Department Accreditation Board is established within the North Carolina Institute for Public Health. The Board shall be composed of 17 members appointed by the Secretary of the Department of Health and Human Services as follows:

(1) Four shall be county commissioners recommended by the North Carolina Association of County Commissioners, and four shall be members of a local board of health as recommended by the Association of North Carolina Boards of Health.

(2) Three local health directors.

(3) Two staff members from the Division of Public Health, Department of Health and Human Services.

(4) One staff member from the Division of Environmental Health, recommended by the Secretary of Environment and Natural Resources.

(5) Three at large.

(b) Members shall serve four-year terms except that initial terms shall be staggered such that three members are appointed for one year, four members are appointed for two years, four members are appointed for three years, and six members are appointed for four years. An appointment to fill a vacancy on the Board created by the resignation, dismissal, ineligibility, death, or disability of any member shall be made for the balance of the unexpired term. The Secretary may remove any member for misfeasance, malfeasance, or nonfeasance. The chair shall be designated by the Secretary and shall designate the times and places at which the Board shall meet. The Board shall meet as often as necessary to carry out its duty to develop and review periodically accreditation standards, to engage in activities necessary to assign accreditation status to local health departments, and to engage in other activities necessary to implement this section.

(c) Members of the Board who are not officers or employees of the State shall receive reimbursement for travel and subsistence expenses at the rates specified in G.S. 138-5. Members of the Board who are officers or employees of the State shall receive reimbursement for travel and subsistence at the rate set out in G.S. 138-6.

(d) The Board shall assign an accreditation status to each local health department that applies for initial accreditation, reaccreditation, or relief from conditional accreditation. The Board shall assign the appropriate accreditation status, as follows:

(1) Accredited, which means that the local health department has satisfied the accreditation standards adopted by the Board and applicable rules adopted by the Commission.

(2) Conditionally accredited, which means that the local health department has failed to meet one or more accreditation standards and has therefore been granted short-term accreditation subject to conditions specified by the Board.

(3) Unaccredited, which means that the local health department has continued to fail to meet one or more accreditation standards after a period of conditional accreditation.

(e) The Commission shall, after reviewing standards developed by and consulting with the Board, adopt rules establishing accreditation standards for local health departments. The accreditation standards shall include at least all of the following:

(1) An accreditation process that consists of the following components:

a. A self-assessment conducted by the local health department seeking accreditation.

b. A site visit by a team of experts to clarify, verify, and amplify the information in the self-assessment.

c. Final action by the Board on the local health department's accreditation status.

(2) The local health department's capacity to provide the essential public health services, as follows:

a. Monitoring health status to identify community health problems.
b. Diagnosing and investigating health hazards in the community.
c. Informing, educating, and empowering people about health issues.
d. Mobilizing community partnerships to identify and solve health problems.
e. Developing policies and plans that support individual and community health efforts.
f. Enforcing laws and regulations that protect health and ensure safety.
g. Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable.
h. Assuring a competent public health workforce and personal health care workforce.
i. Evaluating effectiveness, accessibility, and quality of personal and population-based health services.
j. Conducting research.

(3) The local health department's facilities and administration.

(4) The local health department's staff competencies and training procedures or programs.

(5) The local health department's governance and fiscal management; and

(6) Informal procedures for reviewing Board decisions.

(f) All local health departments shall obtain and maintain accreditation in accordance with this section. The Board shall implement accreditation over a period of eight years, beginning January 1, 2006. The Board shall establish a schedule specifying when each local health department shall apply for initial accreditation and ensuring that all local health departments have applied for initial accreditation by December 1, 2014.

(g) The Board shall assign the following accreditation status, as applicable:

(1) "Accredited" to a local health department that satisfies the accreditation standards. The initial period of accreditation shall expire four calendar years after initial accreditation is granted.

(2) "Conditionally accredited" to a local health department that, in its initial accreditation application, fails to satisfy the accreditation standards. The period of conditional accreditation shall expire two calendar years after conditional accreditation is granted. The Board shall provide to the local health department a written statement of the conditions that must be satisfied in order for the local health department to be accredited. At any time during the two-year period, the local health department may request that its status be reviewed and changed from "conditionally accredited" to "accredited." If the Board finds that the conditions have been met, the Board shall change the local health department's status to "accredited" with the accreditation

period to expire four calendar years after the conditional accreditation was initially granted. If the Board finds that the conditions have not been satisfied, the local health department shall continue under its grant of conditional accreditation. During the conditional accreditation period, the local health department may apply again for accreditation in accordance with rules adopted by the Commission.

(h) Each accredited local health department shall apply for reaccreditation in accordance with rules adopted by the Commission.

(i) When the Board assigns the status "unaccredited" to a local health department, the Board shall send written notification of that status to the local health department and to the Secretary.

(j) The Commission shall adopt rules to implement this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one million two hundred fifty thousand dollars ($1,250,000) for the 2005-2006 fiscal year. These funds shall be allocated to the Local Health Department Accreditation Board to carry out the purposes of this act.

SECTION 3. Section 1 of this act becomes effective October 1, 2005. The remainder of this act becomes effective July 1, 2005.

SENATE BILL 804:
Public Health Task Force/Accred. Recommend

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 2, 2005
Introduced by:	Sen. Hartsell	**Summary by:**	Shawn Parker
Version:	First Edition		Committee Staff

SUMMARY: ***Senate Bill 804 appropriates one million two hundred fifty thousand dollars ($1,250,000) to the Department of Health and Human Services to establish an accreditation system for local health departments as recommended by the Public Health Task Force 2004.***

CURRENT LAW: Local public health services are provided by counties. A county may operate a county health department, establish a consolidated human services agency pursuant to G.S. 153A-77 (counties with a population in excess of 425,000), participate in a district health department, or contract with the State for the provision of health services.[1]

Currently there are 85 public health departments operating in North Carolina.

BILL ANALYSIS: Senate Bill 804 establishes the Local Health Department Accreditation Board, and authorizes the Secretary of the Department of Health and Human Services to appoint 17 members to this Board. The bill also requires the Board to implement accreditation of local health departments over an eight-year period starting January 1, 2006 and ensure that all local health departments shall apply for initial accreditation by December 1, 2014. The Commission for Health Services will adopt rules establishing accreditation standards for local health departments. The process for accreditation must consist of the following components:

- A self-assessment by the local health department.
- A site visit by a team of experts.
- A final action by the Board on the local health department's accreditation status.

The bill appropriates one million two hundred fifty thousand dollars ($1,250,000) from the General Fund to the Department of Health and Human Services to carry out the provisions of this act.

EFFECTIVE DATE: Section 1 of this act becomes effective October 1, 2005. The remainder of this act becomes effective July 1, 2005.

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 proposed legislation is a recommendation from the Public Health Task Force 2004.

S0804e1-SMSQ

[1] G.S.130A-34

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1059

Short Title:	Perfusionists Licensure.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Perfusionist Licensure act.

"**§ 90-681. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-682. Definitions.**

The following definitions apply in this Article:

(1) Advisory Committee. – The North Carolina Perfusion Advisory Committee.

(2) Clinical Certified Perfusionist. – A person who has successfully completed the examination process and has been issued a certificate by the American Board of Cardiovascular Perfusion or its successor organization.

(3) Extracorporeal Circulation. – The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(4) Licensee. – A person who has been issued a license to practice perfusion under this Article.

(5) Perfusion Protocols. – Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician

through collaboration with administrators, licensed perfusionists, and other health care professionals.

(6) Practice of Perfusion. – The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

"**§ 90-683. License required; exemptions.**

(a) On or after July 1, 2006, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist', 'certified clinical perfusionist', or 'provisional licensed perfusionist', use the letters 'LP', 'CCP', or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist, clinical certified perfusionist, or a provisionally licensed perfusionist unless that person is currently licensed or certified as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or

occupation and the person does not represent himself or herself as a licensed perfusionist or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-684. Perfusion Advisory Committee.**

(a) Composition and Terms. – The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of six members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 2005, as follows:

(1) The North Carolina Medical Board shall appoint three licensed perfusionists, two of whom shall serve a term of three years and one of whom shall serve a term of two years.

(2) The North Carolina Medical Board shall appoint one physician who is licensed under Article 1 of Chapter 90 of the General Statutes and is a cardiothoracic surgeon or a cardiovascular anesthesiologist, who shall serve a term of two years.

(3) The North Carolina Hospital Association shall appoint one hospital administrator, who shall serve a term of one year.

(4) The Governor shall appoint one public member who shall serve a term of one year.

Upon the expiration of the terms of the initial Committee members, members shall be appointed by the appointing authorities designated in subdivisions (1) through (4) of subsection (a) of this section for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. – Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Committee.

(c) Vacancies. – Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the

remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. – The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. – Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. – The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. – The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-685. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Determine the qualifications and fitness of applicants for licensure, provisional licensure, licensure renewal, and reciprocal licensure.

(6) Issue, renew, deny, suspend, or revoke licenses, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure, provisional licensure, reciprocal licensure, licensure renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees exist.

(12) Maintain a record of all proceedings and make available to all licensees and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-686. Qualifications for licensure.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Pays the required fee under G.S. 90-689.

(5) Is certified as a certified clinical perfusionist. An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-689.

(b) All persons licensed under this section shall practice perfusion under the supervision of a physician licensed under Article 1 of Chapter 90 of the General Statutes.

"**§ 90-687. Reciprocity.**

The Committee may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-688. Provisional license.**

The Committee may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-689. A provisional license shall allow the individual to practice perfusion under the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license 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. Provisional licenses shall be renewed in accordance with the provisions of G.S. 90-690.

"**§ 90-689. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Issuance of license	$350.00
(3)	Biennial renewal of license	$350.00
(4)	Late renewal of license	$100.00
(5)	Provisional license	$ 35.00
(6)	Copies of rules	Cost

"**§ 90-690. Renewal of licenses.**

(a) All licenses to practice perfusion shall expire two years after the date they were issued. The Committee shall send a notice of expiration to each licensee at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-689.

(b) An application for renewal of a license that has been expired for less than three years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-689. A license that has been expired for more than three years shall not be renewed, but the applicant may apply for a new license by complying with the current requirements for licensure under this Article.

"**§ 90-691. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if the applicant or licensee:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or a license to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-692. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief.

"**§ 90-693. Civil penalties; disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Committee may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of any rules adopted by the Committee. 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, the Committee shall 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 Committee shall establish a schedule of civil penalties for violations of this Article and rules adopted by the Committee.

(d) Costs. – The Committee may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Committee."

SECTION 2. Notwithstanding the requirements of this act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

SECTION 3. G.S. 90-684, as enacted in Section 1 of this act, becomes effective October 1, 2005. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1059
PROPOSED COMMITTEE SUBSTITUTE S1059-CSLU-2 [v.1]

4/22/2005 11:05:58 AM

Short Title: Perfusionists Licensure. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Perfusionist Licensure Act.

"**§ 90-681. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-682. Definitions.**

The following definitions apply in this Article:

(1) Advisory Committee. – The North Carolina Perfusion Advisory Committee.

(2) Clinical Certified Perfusionist. – A person who has successfully completed the examination process and has been issued a certificate by the American Board of Cardiovascular Perfusion or its successor organization.

(3) Extracorporeal Circulation. – The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(4) Licensee. – A person who has been issued a license to practice perfusion under this Article.

(5) Perfusion Protocols. – Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician through collaboration with administrators, licensed perfusionists, and other health care professionals.

(6) Practice of Perfusion. – The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

"**§ 90-683. License required; exemptions.**

(a) On or after July 1, 2006, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist' or 'provisional licensed perfusionist', use the letters 'LP' or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist or a provisionally licensed perfusionist unless that person is currently licensed as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or

occupation and the person does not represent himself or herself as a licensed perfusionist or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-684. Perfusion Advisory Committee.**

(a) Composition and Terms. – The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of seven members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 2005, as follows:

(1) The North Carolina Medical Board shall appoint three licensed perfusionists, two of whom shall serve a term of three years and one of whom shall serve a term of two years.

(2) The North Carolina Medical Board shall appoint one physician who is licensed under Article 1 of Chapter 90 of the General Statutes and is a cardiothoracic surgeon or a cardiovascular anesthesiologist, who shall serve a term of two years.

(3) The North Carolina Hospital Association shall appoint two hospital administrators, one of whom shall serve a term of two years and one of whom shall serve a one-year term.

(4) The Governor shall appoint one public member who shall serve a one-year term.

Upon the expiration of the terms of the initial Committee members, members shall be appointed by the appointing authorities designated in subdivisions (1) through (4) of subsection (a) of this section for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. – Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Committee.

(c) Vacancies. – Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be

filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. – The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. – Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. – The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. – The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-685. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Determine the qualifications and fitness of applicants for licensure, provisional licensure, licensure renewal, and reciprocal licensure.

(6) Issue, renew, deny, suspend, or revoke licenses, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure, provisional licensure, reciprocal licensure, licensure renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees exist.

(12) Maintain a record of all proceedings and make available to all licensees and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-686. Qualifications for licensure.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Pays the required fee under G.S. 90-689.

(5) Is certified as a certified clinical perfusionist. An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-689.

(b) All persons licensed under this section shall practice perfusion under the supervision of a physician licensed under Article 1 of Chapter 90 of the General Statutes.

"**§ 90-687. Reciprocity.**

The Committee may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-688. Provisional license.**

The Committee may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-689. A provisional license shall allow the individual to practice perfusion under the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license 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. Provisional licenses shall be renewed in accordance with the provisions of G.S. 90-690.

"**§ 90-689. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Issuance of license	$350.00
(3)	Biennial renewal of license	$350.00
(4)	Late renewal of license	$100.00
(5)	Provisional license	$ 35.00
(6)	Copies of rules	Cost

"**§ 90-690. Renewal of licenses.**

(a) All licenses to practice perfusion shall expire two years after the date they were issued. The Committee shall send a notice of expiration to each licensee at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-689.

(b) An application for renewal of a license that has been expired for less than three years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-689. A license that has been expired for more than three years shall not be renewed, but the applicant may apply for a new license by complying with the current requirements for licensure under this Article.

"**§ 90-691. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if the applicant or licensee:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or a license to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-692. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief.

"**§ 90-693. Civil penalties; disciplinary costs.**

(a) Authority to Assess Civil Penalties. – The Committee may assess a civil penalty not in excess of one thousand dollars ($1,000) for the violation of any section of this Article or the violation of any rules adopted by the Committee. 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, the Committee shall 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 Committee shall establish a schedule of civil penalties for violations of this Article and rules adopted by the Committee.

(d) Costs. – The Committee may assess the costs of disciplinary actions against a person found to be in violation of this Article or rules adopted by the Committee.

"**§ 90-694. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

SECTION 2. Notwithstanding the requirements of this act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

SECTION 3. G.S. 90-684, as enacted in Section 1 of this act, becomes effective October 1, 2005. The remainder of this act is effective when it becomes law.

SENATE BILL 1059: Perfusionists Licensure

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	April 27, 2005
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin
Version:	First Edition S1059-CSSS		Committee Counsel

SUMMARY: ***Senate Bill 1059 would enact Article 40 of Chapter 90 of the General Statutes requiring licensure of perfusionists. Article 40 – the Perfusionist Licensure Act, would create the North Carolina Perfusion Advisory Committee and would authorize the Committee to determine licensure qualifications and fees and to assess civil penalties for violation of provisions of the act. The bill would also establish minimum qualifications for licensure and set maximum licensure fees.***

The Proposed Committee Substitute would increase the membership of the Committee from six to seven members, would update terminology to reflect the licensed status that perfusionists would have, and would clarify that the bill would not require direct third-party reimbursement to licensed perfusionists.

BILL ANALYSIS: Senate Bill 1059 would enact a new Article of Chapter 90 (Medicine and Allied Occupations) of the General Statutes. Article 40 – the Perfusionist Licensure Act would set forth the following:

Mandatory Licensure – as of July 1, 2006, a current license under the provisions of this Article would be required for a person to practice as a 'licensed perfusionist' (LP) or as a 'provisional licensed perfusionist' (PLP). Several groups of health care personnel would be exempted from this requirement: perfusionists working for the United States government; students enrolled in accredited perfusion education programs if services are supervised by a licensed perfusions and are part of their studies; persons performing autotransfusion or blood conservation techniques under the supervision of a licensed physician; and persons registered, certified, credentialed or licensed to engage in another occupation or profession in the State if they are performing work incidental to the practice of that profession and are not represe4nting themselves as being a LP or PLP.

North Carolina Perfusion Advisory Committee – an appointed seven member committee representing various interested parties, charged with administering the Perfusionist Licensure Act. The Committee would be granted the power and duty to do the following: adopt, amend or repeal rules as necessary to carry out the provisions of the Act; employ and compensate personnel they deem necessary to carry out the provision so f the Act; determine qualifications and fitness of applicants for licensure; issue, renew, deny, suspend or revoke licenses as authorized by the Act; set fees for licensure, renewal and other related services; establish continuing education requirements for licensees; establish a code of ethics; and maintain a current list of licensees.

The Committee would be able to grant reciprocity to persons license to practice perfusion in another state or territory of the United States with substantially equivalent standards of competency. The Committee could also grant a provisional license valid for up to 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee. Provisional licensees would be able to practice perfusion under the supervision and direction of a licensed perfusionist in accordance with rules adopted pursuant to the Act.

Qualifications for Licensure – applicants meeting the following qualifications would be licensed to practice perfusion: be at least 18 years old; complete an application; successfully complete an approved perfusion education program; pay the required fee; and be certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization.

Expenses and fees – fees payable to the Committee would be used to pay all expenses incurred in carrying out the purposes of the Act. The Committee would set the fees charged for applications, renewals, and related actions, not to exceed the amounts set forth in the Act.

Disciplinary Actions – the Committee would be empowered to deny, refuse to renew, suspend, or revoke an application or license or order probation or issue a reprimand if certain specified violations of sections of the Act are taken by a licensee or applicant. Civil penalties not to exceed $1,000 could be assessed for violation of sections of the Act or of any rules adopted by the Committee.

Third Party Reimbursement – nothing in the Act is to be construed to require third-party reimbursements to persons licensed under the Act.

Section 2 of the bill would direct the Committee to issue a license to practice perfusion to any person who has been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application of within five of the last eight years preceding application.

EFFECTIVE DATE: The provision establishing the North Carolina Perfusion Advisory Committee would become effective October 1, 2005. The remainder of the Act would become effective when it becomes law.

BACKGROUND: Perfusionists have been recognized as a definable health profession by the American Medical Association since 1977. Working under the direct supervision of a surgeon, perfusionists are the only non-licensed health care professionals who routinely administer drugs and blood products to patients. A perfusionist is the person responsible for the selection, set up, and operation of the heart-lung machine. To maintain life during open-heart surgery, the patient's heart must be stopped and the patient's blood is diverted outside the body, circulating through the heart-lung machine, and returned to the patient. Certification by the American Board of Cardiovascular Profusion (ABCP) is currently the accepted state and national standard for perfusionists.

S1059e1-SMSS-CSSS

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **May 4, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Brooks	NCSEAA
Mark Fleming	University
Lee Hyde	KCLH
John Bowdish	AstraZeneca
Anne Winn	AHA
Kam Adam	Smith Anderson
Amy Jo Horne	NCMS
Gary Salamido	GSK
Michael Haley	DJJDP
Jessica Sage	NC Family Policy Council
Lyn Wilson	NCALTCF
ANN LOVE	OWHS

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **May 4, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christine Craig	WakeMed
Brian Lewis	Covenant w NC's Children
David Christelli	NC Society of Periodontists
Ian Shearer	NCSP
Stella McKenney	NC DHHS
Jane Smith	NCDHHS/DSS
John Goodman	Alley Associates
Robert S. Clark	Robert S. Clark & Assoc.
M. Dawson	Capitol Group
Steve Shabo	Poyner & Spruill

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **May 4, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rosemary Summers	Orange County Health Department
Debra L Ramey	NCALHD
Tony Troop	NC Division of Social Services
JoAnn Lamm	DHHS/DSS
David Gaskin	A.G.'s Office
René Payne	Nurse of the Day
Melanie Waller	Doctor of the Day
ZEB ALLEY	ALLEY ASSOCIATES
Candace Doyle	NC Society of Perfusion
Khanor Walker	Physician
Tony Rand	NCLM
Katherine Joyce	NCASA

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **May 4, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Wagner	Fay Observer
Bob Hagaman	HHS
Jane Volland	AOC/GAL
DAVID BARNES	Poyner Spruill

AGENDA

SENATE HEALTH CARE COMMITTEE
May 11, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

- **HB 686, Update Disability Statutes/Service Animals** — **Rep. Gibson**
- **SB 705, Amend NC Substance Abuse Act** — **Sen. Nesbitt**
- **SB 960, Study Child Nutrition Services Indir. Costs** — **Sen. Purcell**

III. **Other Business**

IV. **Adjournment**

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, May 12, 2005

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

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

S.B. **960** Study Child Nutrition Services Indir. Costs.

Draft Number:	85235
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

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

Monday, May 16, 2005

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

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

S.B. **705** Amend NC Substance Abuse Act.

Draft Number:	PCS55229
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

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

H.B. **686** Update Disability Statutes/Service Animals.

Draft Number:	PCS60464
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, May 11, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 11, 2005, in Room 544 of the Legislative Office Building, with eleven members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. He recognized residents from the Brody School of Medicine, a third year resident from East Carolina University, and the Doctor and Nurse of the Day.

Senator Purcell introduced Representative Gibson to explain his bill, HB 686, *Update Disability Statutes/Service Animals*, to the Committee and he presented a proposed committee substitute, which was adopted. Senator Lucas moved for an unfavorable report as to the bill, favorable as to the proposed committee substitute. The motion passed.

Senator Nesbitt brought his bill, SB 705, *Amend NC Substance Abuse Act*, forward, with a proposed committee substitute, and a motion was made to adopt it. He asked Jim Scarborough, Executive Director of the North Carolina Substance Abuse Professional Certification Board to explain provisions of the bill. Senator Forrester asked if the bill extends the scope of practice, Mr. Scarborough said that it does not. He asked if substance abuse professionals are allowed to bill directly for their services; the response was yes, that legislation for this was passed in 1999. Senator Nesbitt pointed out that a person can work in this field without being licensed so long as he/she does not claim to be licensed, which would be a Class I misdemeanor. Senator Forrester moved for an unfavorable report as to the original bill, favorable to the proposed committee substitute.

Senator Bingham took the chair for Senator Purcell, who presented his bill, SB 960, *Study Child Nutrition Services Indir. Costs*. He presented a proposed committee substitute, which was adopted. He pointed out that the reimbursement for school meals from federal funds are not sufficient to cover costs of the meals, and that the schools must make up the remainder of the costs. He asked Lynn Hoggard, Section Chief for Child Nutrition Services for the N.C. Department of Public Instruction, for comments. She said that with school budgets shrinking and expenses growing, indirect costs for the school nutrition program are becoming a challenge to the schools to offer healthful meals and snacks. Senator Forrester said that he had read that for the first time in history, children born today have a shorter life span than their parents, largely due to the current obesity problem. Senator Allran asked what indirect costs are. Ms. Hoggard responded that, with respect to school districts' nutrition programs, they are such items as water, electricity or other fuel used for food preparation, use of the physical facility, and central office staff used in support of the nutrition program. Senator Nesbitt made a motion unfavorable to original bill, favorable to the proposed committee substitute. The bill is referred to the Rules Committee.

The meeting adjourned at 11:30 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

HOUSE BILL 686

Short Title:	Update Disability Statutes/Service Animals.	(Public)
Sponsors:	Representatives Gibson; and Faison.	
Referred to:	Health.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LANGUAGE OF CHAPTER 168 OF THE GENERAL STATUTES REGARDING PERSONS WITH DISABILITIES AND TO CLARIFY THE LAW ALLOWING SERVICE ANIMALS IN TRAINING TO ACCESS PUBLIC FACILITIES AND CONVEYANCES WHEN ACCOMPANIED BY A PERSON WHO TRAINS SERVICE ANIMALS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 168 of the General Statutes reads as rewritten:

"**Chapter 168.**

"~~**Handicapped Persons.**~~**Persons with Disabilities.**

"Article 1.

"Rights.

"**§ 168-1. Purpose and definition.**

The State shall encourage and enable ~~handicapped~~ persons with disabilities to participate fully in the social and economic life of the State and to engage in remunerative employment. ~~The definition of "handicapped persons" shall include those individuals with physical, mental and visual disabilities. For the purposes of this Article the definition of "visually impaired" in G.S. 111-11 shall apply.~~ For purposes of this Article, the term "person with a disability" shall have the same meaning as set forth in G.S. 168A-3(7a).

"**§ 168-2. Right of access to and use of public places.**

~~Handicapped persons~~ Persons with disabilities have the same right as ~~the able-bodied~~ persons without disabilities to the full and free use of the streets, highways, sidewalks, walkways, public buildings, public facilities, and all other buildings and facilities, both publicly and privately owned, which serve the public. The Department of Health and Human Services shall develop, print, and promote the publication ACCESS NORTH CAROLINA. It shall make copies of the publication available to the Department of Commerce for its use in Welcome Centers and other appropriate Department of Commerce offices. The Department of Commerce shall promote

ACCESS NORTH CAROLINA in its publications (including providing a toll-free telephone line and an address for requesting copies of the publication) and provide technical assistance to the Department of Health and Human Services on travel attractions to be included in ACCESS NORTH CAROLINA. The Department of Commerce shall forward all requests for mailing ACCESS NORTH CAROLINA to the Department of Health and Human Services.

"**§ 168-3. Right to use of public conveyances, accommodations, etc.**

~~The handicapped and physically disabled~~ Persons with disabilities are entitled to accommodations, advantages, facilities, and privileges of all common carriers, airplanes, motor vehicles, railroad trains, motor buses, streetcars, boats, or any other public conveyances or modes of transportation; hotels, lodging places, places of public accommodation, amusement or resort to which the general public is invited, subject only to the conditions and limitations established by law and applicable alike to all persons.

"**§ 168-4.2. May be accompanied by service animal.**

(a) ~~Every mobility impaired person, as defined in this section, visually impaired person, as broadly defined to include visual disability, hearing impaired person, as defined in G.S. 8B-1(2), or person with a seizure disorder has the right to be accompanied by a service animal especially trained for the purpose of providing assistance to a person with the same impairing condition as the person wishing to be accompanied,~~ Every person with a disability has the right to be accompanied by a service animal trained to assist the person with their specific disability in any of the places listed in G.S. 168-3, and has the right to keep the service animal on any premises the person leases, rents, or uses. The person qualifies for these rights upon the showing of a tag, issued by the Department of Health and Human Services, under G.S. 168-4.3, stamped "NORTH CAROLINA SERVICE ANIMAL PERMANENT REGISTRATION" and stamped with a registration number, or upon a showing that the animal is being trained or has been trained as a service animal. The service animal may accompany a person in any of the places listed in ~~G.S. 168-3 but may not occupy a seat in any of these places.~~ G.S. 168-3. ~~The service animal may accompany that animal's trainer during training sessions in any of the places listed in G.S. 168-3.~~

~~A mobility impaired person is a person with a physiological deficiency, regardless of its cause, nature, or extent, that renders the individual unable to move about without the aid of crutches, a wheelchair, or other form of support, or that limits the person's functional ability to ambulate, climb, descend, sit, rise, or perform any other related function.~~

(b) An animal in training to become a service animal may be taken into any of the places listed in G.S. 168-3 for the purpose of training when the animal is accompanied by a person who is training the service animal and the animal wears a collar and leash, harness, or cape that identifies the animal as a service animal in training. The trainer shall be liable for any damage caused by the animal while using a public conveyance or on the premises of a public facility or other place listed in G.S. 168-3.

"**§ 168-4.3. Training and registration of service animal.**

The Department of Health and Human Services, shall adopt rules for the registration of service animals and shall issue registrations to a ~~visually impaired person, a hearing impaired person, a mobility impaired person, or a person with a seizure disorder~~ person with a disability who makes application for registration of an animal that serves as a service ~~animal.~~ animal or to a person who is training an animal as a service animal.

The rules adopted regarding registration shall require that the animal be trained or be in training as a service ~~animal by an appropriate agency,~~ animal. ~~and that the~~ The rules shall provide that the certification and registration ~~be permanent~~ need not be renewed while the animal is serving or training with the person applying for the registration.~~for the particular animal and need not be renewed while that particular animal serves the person applying for registration as a service animal.~~ No fee may be charged the person for the application, registration, tag, or replacement in the event the original is lost. The Department of Health and Human Services may, by rule, issue a certification or accept the certification issued by the appropriate training facilities.

"**§ 168-4.4. Responsibility for service animal.**

~~The visually impaired person, hearing impaired person, mobility impaired person, or person with a seizure disorder~~ Neither a person with a disability who is accompanied by a service ~~animal~~ animal, nor a person who is training a service animal, may ~~not~~ be required to pay any extra compensation for the animal. The person has all the responsibilities and liabilities placed on any person by any applicable law when that person owns or uses any animal, including liability for any damage done by the animal.

"**§ 168-4.5. Penalty.**

It is unlawful to disguise ~~a dog as an assistance dog, or to deprive a visually impaired person, a hearing impaired person, or a mobility impaired person~~ an animal as a service animal or service animal in training. It is unlawful to deprive a person with a disability or a person training a service animal of any rights granted the person pursuant to G.S. 168-4.2 through G.S. 168-4.4, or of any rights or privileges granted the general public with respect to being accompanied by ~~dogs,~~ animals or to charge any fee for the use of the ~~assistance dog.~~ service animal. Violation of this section shall be a Class 3 misdemeanor.

"**§ 168-4.6. Donation of dogs for training.**

Dogs impounded by a local dog warden that are not redeemed shall be donated to a nonprofit agency engaged in the training of ~~assistance~~ service dogs, upon the agency's request.

~~"§ 168-5. Traffic and other rights of persons using certain canes.~~

~~The driver of a vehicle approaching a visually impaired pedestrian who is carrying a cane predominantly white or silver in color (with or without a red tip) or using a guide dog shall take all necessary precautions to avoid injury to such pedestrian.~~

"**§ 168-8. Right to habilitation and rehabilitation services.**

~~Handicapped persons~~ A person with a disability shall be entitled to such habilitation and rehabilitation services as available and needed for the development or restoration of their capabilities to the fullest extent possible. Such services shall include, but not be limited to, education, training, treatment and other services to provide for adequate food, clothing, housing and transportation during the course of education, training and

treatment. ~~Handicapped persons~~ A person with a disability shall be entitled to these rights subject only to the conditions and limitations established by law and applicable alike to all persons.

"**§ 168.9. Right to housing.**

Each ~~handicapped~~ person with a disability who is a citizen shall have the same right as any other citizen to live and reside in residential communities, homes, and group homes, and no person or group of persons, including governmental bodies or political subdivisions of the State, shall be permitted, or have the authority, to prevent any ~~handicapped~~ person with a disability who is a ~~citizen, on the basis of his or her handicap,~~citizen from living and residing in residential communities, homes, and group homes on the same basis and conditions as any other citizen. Nothing herein shall be construed to conflict with provisions of Chapter 122C of the General Statutes

"**§ 168-10. Eliminate discrimination in treatment of ~~handicapped and disabled.~~ persons with disabilities.**

Each ~~handicapped person~~ person with a disability shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of the person's ~~handicap,~~ disability, shall deny such coverage or benefits. The availability of coverage or benefits shall not be denied solely because of the ~~handicap;~~ disability; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other persons, in accordance with actuarial and underwriting principles and other coverage provisions prescribed in Chapter 58 of the General Statutes. No insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes shall be prohibited from excluding by waiver or otherwise, any preexisting conditions from coverage as prescribed in G.S. 58-51-15(a)(2)b.

"Article 2.

"Vocational Rehabilitation.

"**§ 168-14. Vocational rehabilitation services for deaf persons.**

The Department of Health and Human Services shall promote the employment of deaf persons in this State. The Department shall assist deaf persons whose disability limits employment opportunities in obtaining gainful employment commensurate with their abilities and in maintaining such employment.

The Department, in furtherance of these objectives, shall maintain statistics regarding trades and occupations in which deaf persons are employed.

The Department shall attempt to employ deaf persons in its vocational rehabilitation services for deaf persons and shall have at least one deaf person so employed.

"Article 3.

"Family Care Homes.

"**§ 168-20. Public policy.**

The General Assembly has declared in Article 1 of this Chapter that it is the public policy of this State to provide ~~handicapped~~ persons with disabilities with the opportunity to live in a normal residential environment.

"**§ 168-21. Definitions.**

As used in this Article:

(1) "Family care home" means a home with support and supervisory personnel that provides room and board, personal care and habilitation services in a family environment for not more than six resident ~~handicapped persons.~~ persons with disabilities.

(2) ~~"Handicapped person"~~ "Person with disabilities" means a person with a temporary or permanent physical, emotional, or mental disability including but not limited to mental retardation, cerebral palsy, epilepsy, autism, hearing and sight impairments, emotional disturbances and orthopedic impairments but not including mentally ill persons who are dangerous to others as defined in G.S. 122C-3(11)b.

"**§ 168-22. Family care home; zoning and other purposes.**

(a) A family care home shall be deemed a residential use of property for zoning purposes and shall be a permissible use in all residential districts of all political subdivisions. No political subdivision may require that a family care home, its owner, or operator obtain, because of the use, a conditional use permit, special use permit, special exception or variance from any such zoning ordinance or plan; provided, however, that a political subdivision may prohibit a family care home from being located within a one-half mile radius of an existing family care home.

(b) A family care home shall be deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and improvements.

"**§ 168-23. Certain private agreements void.**

Any restriction, reservation, condition, exception, or covenant in any subdivision plan, deed, or other instrument of or pertaining to the transfer, sale, lease, or use of property which would permit residential use of property but prohibit the use of such property as a family care home shall, to the extent of such prohibition, be void as against public policy and shall be given no legal or equitable force or effect."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 686
PROPOSED SENATE COMMITTEE SUBSTITUTE H686-PCS60464-SS-16

Short Title: Update Disability Statutes/Service Animals. (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LANGUAGE OF CHAPTER 168 OF THE GENERAL STATUTES REGARDING PERSONS WITH DISABILITIES AND TO CLARIFY THE LAW ALLOWING SERVICE ANIMALS IN TRAINING TO ACCESS PUBLIC FACILITIES AND CONVEYANCES WHEN ACCOMPANIED BY A PERSON WHO TRAINS SERVICE ANIMALS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 168 of the General Statutes reads as rewritten:

"**Chapter 168.**

"~~Handicapped Persons.~~Persons with Disabilities.

"Article 1.

"Rights.

"**§ 168-1. Purpose and definition.**

The State shall encourage and enable ~~handicapped~~ persons with disabilities to participate fully in the social and economic life of the State and to engage in remunerative employment. ~~The definition of "handicapped persons" shall include those individuals with physical, mental and visual disabilities. For the purposes of this Article the definition of "visually impaired" in G.S. 111-11 shall apply.~~ For purposes of this Article, the term "person with a disability" shall have the same meaning as set forth in G.S. 168A-3(7a).

"**§ 168-2. Right of access to and use of public places.**

~~Handicapped persons~~ Persons with disabilities have the same right as ~~the able-bodied~~ persons without disabilities to the full and free use of the streets, highways, sidewalks, walkways, public buildings, public facilities, and all other buildings and facilities, both publicly and privately owned, which serve the public. The Department of Health and Human Services shall develop, print, and promote the publication ACCESS NORTH CAROLINA. It shall make copies of the publication available to the Department of Commerce for its use in Welcome Centers and other appropriate

Department of Commerce offices. The Department of Commerce shall promote ACCESS NORTH CAROLINA in its publications (including providing a toll-free telephone line and an address for requesting copies of the publication) and provide technical assistance to the Department of Health and Human Services on travel attractions to be included in ACCESS NORTH CAROLINA. The Department of Commerce shall forward all requests for mailing ACCESS NORTH CAROLINA to the Department of Health and Human Services.

"**§ 168-3. Right to use of public conveyances, accommodations, etc.**

~~The handicapped and physically disabled~~ Persons with disabilities are entitled to accommodations, advantages, facilities, and privileges of all common carriers, airplanes, motor vehicles, railroad trains, motor buses, streetcars, boats, or any other public conveyances or modes of transportation; hotels, lodging places, places of public accommodation, amusement or resort to which the general public is invited, subject only to the conditions and limitations established by law and applicable alike to all persons.

"**§§ 168-4, 168-4.1:** Repealed by Session Laws 1985, c. 514, s. 1.

"**§ 168-4.2. May be accompanied by service animal.**

(a) ~~Every mobility impaired person, as defined in this section, visually impaired person, as broadly defined to include visual disability, hearing impaired person, as defined in G.S. 8B-1(2), or person with a seizure disorder has the right to be accompanied by a service animal especially trained for the purpose of providing assistance to a person with the same impairing condition as the person wishing to be accompanied,~~ Every person with a disability has the right to be accompanied by a service animal trained to assist the person with his or her specific disability in any of the places listed in G.S. 168-3, and has the right to keep the service animal on any premises the person leases, rents, or uses. The person qualifies for these rights upon the showing of a tag, issued by the Department of Health and Human Services, under G.S. 168-4.3, stamped "NORTH CAROLINA SERVICE ANIMAL PERMANENT REGISTRATION" and stamped with a registration number, or upon a showing that the animal is being trained or has been trained as a service animal. The service animal may accompany a person in any of the places listed in ~~G.S. 168-3 but may not occupy a seat in any of these places.~~ G.S. 168-3. ~~The service animal may accompany that animal's trainer during training sessions in any of the places listed in G.S. 168-3.~~

~~A mobility impaired person is a person with a physiological deficiency, regardless of its cause, nature, or extent, that renders the individual unable to move about without the aid of crutches, a wheelchair, or other form of support, or that limits the person's functional ability to ambulate, climb, descend, sit, rise, or perform any other related function.~~

(b) An animal in training to become a service animal may be taken into any of the places listed in G.S. 168-3 for the purpose of training when the animal is accompanied by a person who is training the service animal and the animal wears a collar and leash, harness, or cape that identifies the animal as a service animal in training. The trainer shall be liable for any damage caused by the animal while using a

public conveyance or on the premises of a public facility or other place listed in G.S. 168-3.

"§ 168-4.3. Training and registration of service animal.

The Department of Health and Human Services, shall adopt rules for the registration of service animals and shall issue registrations to a ~~visually impaired person, a hearing impaired person, a mobility impaired person, or a person with a seizure disorder~~ person with a disability who makes application for registration of an animal that serves as a service ~~animal.~~ animal or to a person who is training an animal as a service animal.

The rules adopted regarding registration shall require that the animal be trained or be in training as a service ~~animal by an appropriate agency,~~ animal. ~~and that the~~ The rules shall provide that the certification and registration ~~be permanent~~ need not be renewed while the animal is serving or training with the person applying for the registration.~~for the particular animal and need not be renewed while that particular animal serves the person applying for registration as a service animal.~~ No fee may be charged the person for the application, registration, tag, or replacement in the event the original is lost. The Department of Health and Human Services may, by rule, issue a certification or accept the certification issued by the appropriate training facilities.

"§ 168-4.4. Responsibility for service animal.

~~The visually impaired person, hearing impaired person, mobility impaired person, or person with a seizure disorder~~ Neither a person with a disability who is accompanied by a service ~~animal~~ animal, nor a person who is training a service animal, may ~~not~~ be required to pay any extra compensation for the animal. The person has all the responsibilities and liabilities placed on any person by any applicable law when that person owns or uses any animal, including liability for any damage done by the animal.

"§ 168-4.5. Penalty.

It is unlawful to disguise ~~a dog as an assistance dog, or to deprive a visually impaired person, a hearing impaired person, or a mobility impaired person~~ an animal as a service animal or service animal in training. It is unlawful to deprive a person with a disability or a person training a service animal of any rights granted the person pursuant to G.S. 168-4.2 through G.S. 168-4.4, or of any rights or privileges granted the general public with respect to being accompanied by ~~dogs,~~ animals or to charge any fee for the use of the ~~assistance dog.~~ service animal. Violation of this section shall be a Class 3 misdemeanor.

"§ 168-4.6. Donation of dogs for training.

Dogs impounded by a local dog warden that are not redeemed shall be donated to a nonprofit agency engaged in the training of ~~assistance~~ service dogs, upon the agency's request.

~~**"§ 168-5. Traffic and other rights of persons using certain canes.**~~

~~The driver of a vehicle approaching a visually impaired pedestrian who is carrying a cane predominantly white or silver in color (with or without a red tip) or using a guide dog shall take all necessary precautions to avoid injury to such pedestrian.~~

"§ 168-6: Repealed by Session Laws 1985, c. 571, s. 3.

"§§ 168-7, 168-7.1: Repealed by Session Laws 1985, c. 514, s. 1.

"§ 168-8. Right to habilitation and rehabilitation services.

~~Handicapped persons~~ A person with a disability shall be entitled to such habilitation and rehabilitation services as available and needed for the development or restoration of their capabilities to the fullest extent possible. Such services shall include, but not be limited to, education, training, treatment and other services to provide for adequate food, clothing, housing and transportation during the course of education, training and treatment. ~~Handicapped persons~~ A person with a disability shall be entitled to these rights subject only to the conditions and limitations established by law and applicable alike to all persons.

"§ 168.9. Right to housing.

Each ~~handicapped~~ person with a disability who is a citizen shall have the same right as any other citizen to live and reside in residential communities, homes, and group homes, and no person or group of persons, including governmental bodies or political subdivisions of the State, shall be permitted, or have the authority, to prevent any ~~handicapped~~ person with a disability who is a ~~citizen, on the basis of his or her handicap,~~citizen from living and residing in residential communities, homes, and group homes on the same basis and conditions as any other citizen. Nothing herein shall be construed to conflict with provisions of Chapter 122C of the General Statutes.

"§ 168-10. Eliminate discrimination in treatment of ~~handicapped and disabled.~~ persons with disabilities.

Each ~~handicapped person~~ person with a disability shall have the same consideration as any other person for individual accident and health insurance coverage, and no insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes solely on the basis of the person's ~~handicap,~~ disability, shall deny such coverage or benefits. The availability of coverage or benefits shall not be denied solely because of the ~~handicap;~~ disability; however, any such insurer may charge the appropriate premiums or fees for the risk insured on the same basis and conditions as insurance issued to other persons, in accordance with actuarial and underwriting principles and other coverage provisions prescribed in Chapter 58 of the General Statutes. No insurer, service corporation, multiple employer welfare arrangement, or health maintenance organization subject to Chapter 58 of the General Statutes shall be prohibited from excluding by waiver or otherwise, any preexisting conditions from coverage as prescribed in G.S. 58-51-15(a)(2)b.

"§§ 168-11 through 168-13: Reserved for future codification purposes.

"Article 2.

"Vocational Rehabilitation.

"§ 168-14. Vocational rehabilitation services for deaf persons.

The Department of Health and Human Services shall promote the employment of deaf persons in this State. The Department shall assist deaf persons whose disability limits employment opportunities in obtaining gainful employment commensurate with their abilities and in maintaining such employment.

The Department, in furtherance of these objectives, shall maintain statistics regarding trades and occupations in which deaf persons are employed.

The Department shall attempt to employ deaf persons in its vocational rehabilitation services for deaf persons and shall have at least one deaf person so employed.

"**§§ 168-15 through 168-19:** Reserved for future codification purposes.

"Article 3.

"Family Care Homes.

"**§ 168-20. Public policy.**

The General Assembly has declared in Article 1 of this Chapter that it is the public policy of this State to provide ~~handicapped~~ persons with disabilities with the opportunity to live in a normal residential environment.

"**§ 168-21. Definitions.**

As used in this Article:

(1) "Family care home" means a home with support and supervisory personnel that provides room and board, personal care and habilitation services in a family environment for not more than six resident ~~handicapped persons.~~ persons with disabilities.

(2) ~~"Handicapped person"~~ "Person with disabilities" means a person with a temporary or permanent physical, emotional, or mental disability including but not limited to mental retardation, cerebral palsy, epilepsy, autism, hearing and sight impairments, emotional disturbances and orthopedic impairments but not including mentally ill persons who are dangerous to others as defined in G.S. 122C-3(11)b.

"**§ 168-22. Family care home; zoning and other purposes.**

(a) A family care home shall be deemed a residential use of property for zoning purposes and shall be a permissible use in all residential districts of all political subdivisions. No political subdivision may require that a family care home, its owner, or operator obtain, because of the use, a conditional use permit, special use permit, special exception or variance from any such zoning ordinance or plan; provided, however, that a political subdivision may prohibit a family care home from being located within a one-half mile radius of an existing family care home.

(b) A family care home shall be deemed a residential use of property for the purposes of determining charges or assessments imposed by political subdivisions or businesses for water, sewer, power, telephone service, cable television, garbage and trash collection, repairs or improvements to roads, streets, and sidewalks, and other services, utilities, and improvements.

"**§ 168-23. Certain private agreements void.**

Any restriction, reservation, condition, exception, or covenant in any subdivision plan, deed, or other instrument of or pertaining to the transfer, sale, lease, or use of property which would permit residential use of property but prohibit the use of such property as a family care home shall, to the extent of such prohibition, be void as against public policy and shall be given no legal or equitable force or effect."

SECTION 2. This act becomes effective September 1, 2005.

HOUSE BILL 686:
Update Disability Statutes/Service Animals

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 10, 2005
Introduced by:	Rep. Gibson	**Summary by:**	Ben Popkin
Version:	PCS to First Edition H686-CSSS		Committee Counsel

SUMMARY: ***House Bill 686 would update the language used in Chapter 168 of the General Statutes to reflect current preference for 'person first' terminology that emphasizes the individual rather than their disability. This is accomplished by replacing the outdated term 'handicapped persons' with the preferred term 'persons with disabilities'. This bill also grants every person with a disability the right to be accompanied by any service animal that has been trained to help assist the person with their specific disability. Finally, this bill would remove the section requiring drivers to 'take all necessary precautions' when driving a vehicle around a visually impaired person using a cane or accompanied by a guide dog.***

CURRENT LAW: Chapter 168 of the General Statutes – "Handicapped Persons", sets forth provisions that aim to "...encourage and enable handicapped persons to participate fully in the social and economic life of the State and to engage in remunerative employment."[1] The three Articles of Chapter 168, "Rights", "Vocational Rehabilitation", and "Family Care Homes", address the rights of persons with disabilities and identifies services provided by the State for these persons.

BILL ANALYSIS: House Bill 686 would update language throughout Chapter 168 to replace the outdated terminology emphasizing an individual's handicap or impairment with the current, preferred terminology emphasizing the 'person first', using the term "person with a disability" as defined in the General Statutes[2]. This update begins with the title of the Chapter itself – "Persons with Disabilities", and continues throughout the body of the Chapter. In addition to the terminology update, this bill would make two changes to current law.

1) Service Animals – The right to be accompanied by a service animal trained to assist a person with their specific disability would be expanded to include every person with a disability, rather than the current grouping of individuals who are visually impaired, hearing impaired, mobility impaired or have a seizure disorder. Animals in training to become service animals would be allowed access to areas equal to those allowed for fully trained service animals for the purpose of training, when accompanied by their trainer[3].

2) Traffic rights of the visually impaired – The existing section directing drivers to take 'all necessary precautions' when approaching visually impaired pedestrians carrying certain canes or using guide dogs would be deleted.

EFFECTIVE DATE: The act would be effective on September 1, 2005.

H0686e1-SMSS-CSSS

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[1] G.S. 168-1.
[2] G.S. 168A-3(7a).
[3] G.S. 168-3

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 705

Short Title:	Amend NC Substance Abuse Act.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:	Judiciary I.	

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE LICENSURE OF SUBSTANCE ABUSE PROFESSIONALS, TO ESTABLISH THE CREDENTIAL OF CERTIFIED CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL, AND TO ALLOW THE DEPARTMENT OF JUSTICE TO CONDUCT CRIMINAL HISTORY RECORD CHECKS FROM STATE AND NATIONAL REPOSITORIES OF CRIMINAL HISTORY OF APPLICANTS FOR CREDENTIALS UPON THE REQUEST OF THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. Article 5C of Chapter 90 of the General Statutes reads as rewritten:

"Article 5C.

"North Carolina Substance Abuse ~~Professionals Certification~~Professional Practice Act.

"§ 90-113.30. Declaration of purpose.

The North Carolina Substance Abuse Professional ~~Certification~~ Practice Board, established by G.S. 90-113.32, is recognized as the ~~certifying~~ registering, certifying, and licensing authority for substance abuse professionals described in this Article in order to safeguard the public health, safety, and welfare, to protect the public from being harmed by unqualified persons, to assure the highest degree of professional care and conduct on the part of ~~certified~~ credentialed substance abuse professionals, to provide for the establishment of standards for the education of ~~certified~~ credentialed substance abuse professionals, and to ensure the availability of ~~certified~~ credentialed substance abuse professional services of high quality to persons in need of these services. It is the purpose of this Article to provide for the regulation of ~~Board certified~~Board-credentialed persons offering substance abuse counseling services, substance abuse prevention services, or any other substance abuse services for which the Board may grant ~~certification.~~registration, certification, or licensure.

~~**"90-113.31. Definitions.**~~

~~The following definitions shall apply in this Article:~~

~~(1) Approved supervisor. A person who provides supervision as required by the Board to persons applying for registration or certification as a substance abuse professional pursuant to this Article.~~

~~(1a) Board. The North Carolina Substance Abuse Professional Certification Board.~~

~~(1b) Certified clinical addictions specialist. A person certified by the Board to practice as a clinical addictions specialist in accordance with the provisions of this Article.~~

~~(1c) Certified clinical supervisor. A person certified by the Board to practice as a clinical supervisor in accordance with the provisions of this Article.~~

~~(1d) Certified residential facility director. A person certified by the Board to practice as a residential facility director in accordance with the provisions of this Article.~~

~~(2) Certified substance abuse counselor. A person certified by the Board to practice as a substance abuse counselor in accordance with the provisions of this Article.~~

~~(3) Repealed by S.L. 1997-492, s. 2.~~

~~(3a) Certified substance abuse prevention consultant. A person certified by the Board to practice substance abuse prevention in accordance with the provisions of this Article.~~

~~(4) Clinical supervisor intern. A person designated by the Board to practice as a clinical supervisor intern for a period not to exceed three years without a showing of good cause in accordance with the provisions of this Article.~~

~~(4a) Credentialing body. A board that licenses, certifies, or regulates a profession or practice.~~

~~(4b) Deemed status. Recognition by the Board of the credentials offered by a professional discipline whereby the individuals certified, licensed, or otherwise recognized by the discipline as having met the standards of a substance abuse specialist may apply individually for certification as a certified clinical addictions specialist.~~

~~(4c) Human services field. An area of study that focuses on the biological, psychological, and social aspects of human beings.~~

~~(4d) Repealed by Session Laws 1999-164, s. 1.~~

~~(5) Prevention. The reduction, delay, or avoidance of alcohol and of other drug use behavior. "Prevention" includes the promotion of positive environments and individual strengths that contribute to personal health and well-being over an entire life and the development of strategies that encourage individuals, families, and communities to take part in assessing and changing their lifestyle and environments.~~

~~(6) Professional discipline. A field of study characterized by the technical, educational, and ethical standards of a profession.~~

~~(6a) Registrant. – A person who has initiated a certification process to become a certified substance abuse counselor or a certified clinical addictions specialist pursuant to this Article and is authorized to provide DWI assessments pursuant to G.S. 122C-142.1.~~

~~(7) Substance abuse counseling. – The assessment, evaluation, and provision of counseling to persons suffering from substance, drug, or alcohol abuse or dependency.~~

~~(7a) Substance abuse counselor intern. – A person who successfully completes 300 hours of Board approved supervised practical training and a written examination in pursuit of certification as a substance abuse counselor.~~

~~(8) Substance abuse professional. – A certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director.~~

"**§ 90-113.31A. Definitions.**

The following definitions shall apply in this Article:

(1) Applicant. – A person who has initiated a process to become a substance abuse professional pursuant to this Article.

(2) Applicant supervisor. – A person who provides supervision as required by the Board to persons applying for registration, certification, or licensure as a substance abuse professional pursuant to this Article.

(3) Board. – The North Carolina Substance Abuse Professional Practice Board.

(4) Certified clinical supervisor. – A person certified by the Board to practice as a clinical supervisor in accordance with the provisions of this Article.

(5) Certified criminal justice addictions professional. – A person certified by the Board to practice as a criminal justice addictions professional who under supervision provides direct services to clients or offenders exhibiting substance abuse disorders and works in a program determined by the Board to be involved in a criminal justice setting.

(6) Certified substance abuse counselor. – A person certified by the Board to practice under the supervision of a practice supervisor as a substance abuse counselor in accordance with the provisions of this Article.

(7) Certified substance abuse prevention consultant. – A person certified by the Board to practice substance abuse prevention in accordance with the provisions of this Article.

(8) Certified substance abuse residential facility director. – A person certified by the Board to practice as a substance abuse residential facility director in accordance with the provisions of this Article.

(9) Clinical addictions specialist intern. – A person who successfully completes 300 hours of Board-approved supervised practical training

and passes a written examination in pursuit of licensure as a clinical addictions specialist.

(10) Clinical supervisor intern. – A person designated by the Board to practice as a clinical supervisor under the supervision of a certified clinical supervisor for a period not to exceed three years without a showing of good cause in accordance with the provisions of this Article.

(11) Counseling. – The utilization of special skills to assist individuals, families, or groups in achieving objectives, including the following:

a. Exploring a problem and its ramifications.

b. Examining attitudes and feelings.

c. Considering alternative solutions.

d. Decision making.

(12) Credential. – Any registration, certification, or license issued by the Board.

(13) Credentialing body. – A board that licenses, certifies, registers, or otherwise regulates a profession or practice.

(14) Criminal history. – A history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice substance abuse professional services. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(15) Deemed status. – Recognition by the Board of the credentials offered by a professional discipline whereby the individuals certified, licensed, or otherwise recognized by the discipline as having met the standards of a clinical addictions specialist may apply individually for licensure as a licensed clinical addictions specialist.

(16) Dual relationship. – A relationship in addition to the professional relationship with a person to whom the substance abuse professional delivers services in the Twelve Core Functions or the performance domains, both as defined in rules adopted by the Board, or as provided in a supervisory capacity. These relationships may result in grounds for disciplinary action.

(17) Human services field. – An area of study that focuses on the biological, psychological, behavioral, and social aspects of human welfare with focus on the direct services designed to improve it.

(18) Independent study. – Any course of study that is not traditional classroom-based that must be preapproved by the Board or any organization that has deemed status with the Board.

(19) Licensed clinical addictions specialist. – A person licensed by the Board to practice as a clinical addictions specialist in accordance with the provisions of this Article.

(20) Practice supervisor. – A certified clinical supervisor, clinical supervisor intern, or licensed clinical addictions specialist who provides oversight and responsibility in a face-to-face capacity for each certified substance abuse counselor or criminal justice addictions professional.

(21) Prevention. – The reduction, delay, or avoidance of alcohol and of other drug use behavior. 'Prevention' includes the promotion of positive environments and individual strengths that contribute to personal health and well-being over an entire life and the development of strategies that encourage individuals, families, and communities to take part in assessing and changing their lifestyle and environments.

(22) Professional discipline. – A field of study characterized by the technical, educational, and ethical standards of a profession.

(23) Registrant. – A person who completes all requirements to be registered with the Board and is supervised by a certified clinical supervisor or clinical supervisor intern.

(24) Substance abuse counseling. – The assessment, evaluation, and provision of counseling and therapeutic service to persons suffering from substance abuse or dependency.

(25) Substance abuse counselor intern. – A person who successfully completes 300 hours of Board-approved supervised practical training and passes a written examination in pursuit of credentialing as a substance abuse counselor.

(26) Substance abuse professional. – A registrant, certified substance abuse counselor, substance abuse counselor intern, certified substance abuse prevention consultant, certified clinical supervisor, clinical addictions specialist intern, licensed clinical addictions specialist, certified substance abuse residential facility director, or certified criminal justice addictions professional.

"**§ 90-113.31B. Scope of practice.**

The scope of practice is the use by all substance abuse professionals and their ongoing supervisees of principles, methods, and procedures of the Twelve Core Functions or performance domains as prescribed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated and as limited by individual credential and supervisory requirements pursuant to this Article. Specifically, the scope of practice for each individual defined as a substance abuse professional under G.S. 90-113.31A is as follows:

(1) The practice of a certified substance abuse counselor consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, and referral to treat addictive disorder or disease and help prevent relapse.

(2) The practice of a certified substance abuse prevention consultant is based on knowledge in the performance domains to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease and help prevent relapse.

(3) The practice of a certified clinical supervisor is based on knowledge in the performance domains to supervise substance abuse professionals who work to treat, prevent, or reduce the conditions that place individuals at risk of developing addictive disorder or disease and help prevent relapse.

(4) The practice of licensed clinical addictions specialist may be independent and consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, referral to reduce the conditions that place individuals at risk of developing addictive disorder or disease with co-occurring disorders, and treatment for addictive disorder or disease. The licensed clinical addictions specialist may provide supervision to maintain a professional credential as defined by this Article.

(5) The practice of certified substance abuse residential facility director is a voluntary credential and consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client

education, record and record keeping, consultation with professionals in regard to client treatment and services, referral to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease, treatment for addictive disorder or disease, and the prevention of relapse as well as academic management training.

(6) The practice of certified criminal justice addictions professional is based on knowledge in the performance domains of dynamics of addiction in criminal behavior; legal, ethical, and professional responsibility; criminal justice system and processes; screening, intake, and assessment; case management; monitoring; and client supervision and counseling to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease, treat addictive disorder or disease, and help prevent relapse.

"**§ 90-113.32. Board; composition; voting.**

(a) The Board is created as the ~~certifying~~ authority ~~for substance abuse counselors, substance abuse prevention consultants, clinical supervisors, clinical addictions specialists, and residential facility directors~~to credential substance abuse professionals in North Carolina.

(b) Until the full Board is elected or appointed pursuant to subsection (c) of this section, the Board shall consist of 16 members with one member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121, and one member appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. The remaining 14 shall be those members of the current North Carolina Substance Abuse Professional ~~Certification~~ Practice Board, Inc., who have terms that are unexpired as of the effective date of this Article. The initial Board shall appoint an initial Nominating and Elections Committee to fill immediate vacancies on the Board, using the process established in subsection (d) of this section. The election and appointment process of the initial Board shall result in a Board of 19 members by April 1, 1995. As these initial members' terms expire, their successors shall be appointed as described in subsection (c) of this section, until the permanent Board is established, as described in subsection (c) of this section. Time spent as an initial member counts in determining the limitation on consecutive terms prescribed in subsection (e) of this section.

(c) After the initial Board members' terms expire, the Board shall consist of the following members, all of whom shall reside in North Carolina, appointed or elected as follows:

(1) Eleven professionals ~~certified~~ credentialed pursuant to this Article and elected by the ~~certified~~ credentialed professionals, at least two of whom shall serve each of the four Division of Mental Health, Developmental Disabilities, and Substance Abuse Services regions of the State. Three members shall serve as members at large.

(2) Three members at large chosen from laypersons or other professional disciplines who have shown a special interest in the field of substance abuse, nominated by the Nominating and Elections Committee established by subsection (d) of this section and elected by the Board.

(3) Two members from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, appointed by the Chief of ~~Substance Abuse Services Section, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services,~~the North Carolina Substance Abuse Single State Agency, at least one of whom ~~is from the Substance Abuse Services Section.~~administers substance abuse services.

(4) One member of the public at large appointed by the Governor.

(5) One member of the public at large appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121 and one member of the public at large appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121.

(6) One member shall represent each of the professional disciplines granted deemed status under G.S. 90-113.41A. The member may be appointed by the professional discipline on or before a date set by the Board. If the professional discipline has at least one association in the State, the member shall be chosen from a list of nominees submitted to the association. The members appointed or elected under this subdivision shall be certified as substance abuse specialists by the professional discipline that the members represent.

No member of the General Assembly shall serve on the Board.

(c1) Every member of the Board shall have the right to vote on all matters before the Board, except for the President who shall vote only in case of a tie or when another member of the Board abstains on the question of whether the professional discipline the member represents shall retain its deemed status.

(d) The Board shall appoint five professionals from the field of substance abuse counseling and substance abuse prevention consulting to serve on the Nominating and Elections Committee. Of these five, at least three shall not be members of the Board. The Board shall appoint a member of the Nominating and Elections Committee to serve as chair. The Committee's purpose is to accept nominations from professionals certified or licensed by the Board to fill vacancies on the Board in membership categories prescribed by subdivisions (1) and (2) of subsection (c) of this section and to conduct the election of Board members. The Committee shall solicit nominations from all professionals it has certified or licensed under this Article when elected members' terms are due to expire. The certified or licensed professionals shall submit to the Committee all nominations beginning 90 days and ending ~~14~~ 28 days before the election of new Board members. The Committee shall furnish all certified or licensed professionals with

a ballot containing all the nominees for each elected Board member vacancy. In soliciting and making nominations for this process, the Committee shall give consideration to factors that promote representation on the Board by professionals certified or licensed by the Board. The Committee shall serve for a two-year term, its successors to be appointed for the same term by the Board.

(e) Members of the Board shall serve for ~~three-year~~four-year terms. No Board member shall serve for more than two consecutive terms, but a person who has been a member for two consecutive terms may be reappointed after being off the Board for a period of at least one year. When a vacancy occurs in an unexpired term, the Board shall, as soon as practicable, appoint temporary members to serve until the end of the unexpired terms. Time spent as a temporary member does not count in determining the limitation on consecutive terms.

(f) If a member becomes ineligible to serve on the Board for any reason, except when the member has committed an ethical violation that results in the suspension or revocation of the member's professional credentials, ~~the~~ that member may fulfill the remainder of ~~the member's~~his or her term on the Board.

"**§ 90-113.33. Board; powers and duties.**

The Board shall:

(1) Examine and determine the qualifications and fitness of applicants for certification and licensure to practice in this State.

(1a) Determine the qualifications and fitness of organizations applying for deemed status.

(2) Issue, renew, deny, suspend, or revoke ~~certification~~ licensure, certification, or registration to practice in this State or reprimand or otherwise discipline ~~certificate~~ a license, certificate, or registration ~~holders~~ holder in this State. ~~Denial of an applicant's certification or registration or the granting of certification or registration on a probationary or other conditional status shall be subject to substantially the same rules and procedures prescribed by the Board for review and disciplinary actions against those persons holding certificates or registrations. Disciplinary actions involving a clinical addictions specialist whose certification is achieved through deemed status shall be initially heard by the specialist's credentialing body. The specialist may appeal the body's decision to the Board. The Board shall, however, have the authority to hear the initial disciplinary action involving a clinical addictions specialist.~~

(3) Deal with issues concerning reciprocity.

(4) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining exists.

(5) Employ ~~the professional and clerical~~and fix the compensation of personnel and legal counsel that the Board determines is necessary to carry out the provisions of this Article. The Board may purchase or rent necessary office space, equipment, and supplies.

(6) Conduct administrative hearings in accordance with Chapter 150B of the General Statutes when a "contested case", as defined in Chapter 150B, arises.

(7) Appoint from its own membership one or more members to act as representatives of the Board at any meeting in which it considers this representation is desirable.

(8) Establish fees for applications for examination, registration, certificates of ~~certification~~ certification, licensure, and renewal, and other services provided by the Board.

(9) Adopt any rules necessary to carry out the purpose of this Article and its duties and responsibilities pursuant to this Article.

(10) Request that the Department of Justice conduct criminal history record checks of applicants for registration, certification, or licensure pursuant to G.S. 114-19.11A.

The powers and duties enumerated in this section are granted for the purposes of enabling the Board to safeguard the public health, safety, and welfare against unqualified or incompetent practitioners and are to be liberally construed to accomplish this objective. When the Board exercises its authority under this Article to discipline a person, it may, as part of the decision imposing the discipline, charge the costs of investigations and the ~~hearing~~ hearing, including attorneys' fees, to the person disciplined.

"§ 90-113.33A. Officers may administer oaths, and subpoena witnesses, records, and other materials.

The President or other presiding officer of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The Board may order that any client records, documents, or other materials concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any counselor-client or physician-patient privilege with respect to such records, documents, or other materials. All records, documents, or other materials compiled by the Board are subject to the provisions of G.S. 90-113.34, except that in any proceeding before the Board, record of any hearing before the Board, and notice of charges against any person ~~certified~~ credentialed by the Board, the Board shall withhold from public disclosure the identity of a client, including information relating to dates and places of treatment, or any other information that tends to identify the client unless the client or the client's representative has expressly consented to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence sought does not relate to a matter in issue, the subpoena does not describe the evidence with sufficient particularity, or the subpoena is invalid.

"§ 90-113.34. Records to be kept; copies of records.

(a) The Board shall keep a regular record of its proceedings, together with the names of the members of the Board present, the names of the applicants for registration, certification, and licensure as well as other information relevant to its actions. The Board shall cause a record to be kept that shall show the name, last known place of business, last known place of residence, and date and number of the ~~certificate of certification as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director for every living certified person.~~credential assigned to each substance abuse professional meeting the standards set forth in this Article. Any interested person in the State is entitled to obtain a copy of ~~that record on~~board records upon application to the Board and ~~upon~~ payment of a reasonable charge that is based on the costs involved in providing the copy.

(b) The Board may in a closed session receive evidence regarding the provision of substance abuse counseling or other treatment and services provided to a client who has not expressly or through implication consented to the public disclosure of such treatment as may be necessary for the protection of the rights of the client or of the accused registrant or substance abuse professional and the full presentation of relevant evidence. All records, papers, and other documents containing information collected and compiled by the Board, its members, or employees as a result of investigations, inquiries, or interviews conducted in connection with ~~a certification~~awarding a credential or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes, except any notice or statement of charges, or notice of hearing shall be a public record notwithstanding that it may contain information collected and compiled as a result of an investigation, inquiry, or interview. If any record, paper, or other document containing information collected and compiled by the Board as provided in this subsection is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record.

(c) Notwithstanding any provision to the contrary, the Board may, in any proceeding, record of any hearing, and notice of charges, withhold from public disclosure the identity of a client who has not expressly or through implication consented to such disclosure of treatment by the accused substance abuse professional.

"**§ 90-113.35. Disposition of funds.**

All fees and other moneys collected and received by the Board shall be used to implement this Article. The financial records of the Board shall be subjected to an annual audit and paid for out of the funds of the Board.

"**§ 90-113.36. ~~Certificates of certification.~~Credentials.**

(a) The Board shall furnish a certificate of certification or licensure to each applicant successfully completing the requirements for ~~certification.~~his or her credential.

(b) The Board may furnish a certificate of certification or licensure to any person in another state or territory if the individual's qualifications were, at the date of ~~registration or~~registration, certification, or licensure, substantially equal to the requirements under this Article. However, an out-of-state applicant shall first file application and pay any required fees.

~~"§ 90-113.37. Renewal of certification; lapse; revival.~~

~~(a) Every person certified pursuant to this Article who desires to maintain certification status shall apply to the Board for a renewal of certification every other year and pay to the secretary-treasurer the prescribed fee. Renewal of certification is subject to completion of no more than 60 hours of those continuing education requirements established by the Board. A clinical supervisor shall complete 15 hours of substance abuse clinical supervision training prior to the certificate being renewed. Certification that is not renewed automatically lapses, unless the Board provides for the late renewal of certification upon the payment of a late fee. No late renewal shall be granted more than five years after a certification expires. A suspended certification is subject to this section's renewal requirements and may be renewed as provided in this section. This renewal does not entitle the certified person to engage in the certified activity or in any other conduct or activity in violation of the order or judgment by which the certification was suspended, until the certification is reinstated. If a certification revoked on disciplinary grounds is reinstated and requires renewal, the certified person shall pay the renewal fee and any applicable late fee.~~

~~(b) The Board shall establish the manner in which lapsed certification may be revived or extended.~~

"§ 90-113.37A. Renewal of credential; lapse.

(a) Every person credentialed pursuant to this Article who desires to maintain his or her credentials shall apply to the Board for a renewal of certification or licensure every other year and pay to the treasurer the prescribed fee.

(b) Renewal of licensure is subject to completion of at least 40 hours of the continuing education requirements established by the Board. Renewal of substance abuse counselor or substance abuse prevention consultant certification is subject to completion of at least 60 hours of the continuing education requirements established by the Board. A certified substance abuse counselor shall submit a Board-approved supervision contract signed by the applicant and a practice supervisor documenting ongoing supervision at a ratio of one hour of supervision to every 40 hours of practice after certification is granted by the Board on a form provided by the Board. Any person certified by the Board as a certified alcoholism counselor or certified drug abuse counselor shall become a certified substance abuse counselor.

A clinical supervisor shall complete at least 15 hours of substance abuse clinical supervision training prior to the certificate being renewed. A substance abuse residential facility director shall complete at least 10 hours of substance abuse training for renewal. A certified criminal justice addictions professional shall complete at least 40 hours of continuing education that must be earned in the certified criminal justice addictions professional performance domains. A certified criminal justice addictions professional shall submit a Board-approved supervision contract signed by the criminal justice addictions professional and a practice supervisor documenting ongoing supervision at a ratio of one hour of supervision to every 40 hours of practice after certification is granted by the Board on a form provided by the Board.

(c) Independent study hours shall compose no more than fifty percent (50%) of the total number of hours required for renewal.

(d) A credential that is not renewed automatically lapses, unless the Board approves the late renewal of a credential upon the payment of a late fee.

(e) No late renewal shall be granted more than five years after a certification or licensure expires.

(f) A suspended credential may be renewed as provided in this section. This renewal does not entitle the credentialed person to engage in conduct or activity in violation of the order or judgment by which the credential was suspended, until the credential is reinstated. If a credential revoked on disciplinary grounds is reinstated and requires renewal, the credentialed person shall pay the renewal fee and any applicable late fee.

(g) The Board shall establish the manner in which lapsed certification or licensure may be revived or extended.

"§ 90-113.38. Maximums for certain fees.

(a) The fee to obtain a certificate of certification as a substance abuse counselor, substance abuse prevention consultant, clinical supervisor, ~~or~~ substance abuse residential facility ~~director~~ director, or certified criminal justice addictions professional may not exceed four hundred seventy-five dollars ($475.00). The fee to renew a certificate may not exceed one hundred fifty dollars ($150.00).

(b) The fee to obtain a certificate of ~~certification~~ licensure for a clinical addictions specialist pursuant to deemed status ~~may~~ shall not exceed one hundred fifty dollars ($150.00). The fee to renew a ~~certificate may~~license for a clinical addictions specialist pursuant to deemed status shall not exceed one hundred dollars ($100.00). The fee to obtain a ~~certificate of certification~~license for a clinical addictions specialist pursuant to all other procedures authorized by this Article ~~may~~ shall not exceed four hundred seventy-five dollars ($475.00). The fee to renew the ~~certificate may~~license shall not exceed one hundred fifty dollars ($150.00).

(b1) The fee to obtain a registration as a registrant shall ~~be~~ not exceed one hundred fifty dollars ($150.00). The fee to renew a registration shall ~~be~~ not exceed one hundred fifty dollars ($150.00).

(c) There shall be a reexamination fee of one hundred fifty dollars ($150.00) which shall be paid for each reexamination in addition to the fees ~~required under~~authorized pursuant to subsection (a) of this section. There shall be a fee not to exceed twenty-five dollars ($25.00) for rescheduling any examination.

(d) There shall be a fee ~~of~~ not to exceed twenty-five dollars ($25.00) to obtain a written verification ~~of certification~~or additional copy of a credential issued by the Board.

(e) There shall be a late renewal fee not to exceed one hundred twenty-five dollars ($125.00).

(f) In addition to any other prescribed fees, the Board shall charge a fee not to exceed one hundred fifty dollars ($150.00) for each administration of the test an applicant must pass to be credentialed as a United States Department of Transportation substance abuse professional.

"§ 90-113.39. Standards for ~~certification.~~credentials.

The Board shall establish standards ~~for certification of~~to credential substance abuse professionals. The ~~certification~~ credentialing standards of the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated and the standards adopted by professional disciplines granted deemed status or their successor organizations may be used as guidelines for the Board's standards. The Board shall publish these required ~~standards separately from its rules so as to provide easy access to the~~ standards.

"**§ 90-113.40. Requirements for ~~certification.~~certification and licensure.**

(a) The Board shall issue a certificate certifying an applicant as a "Certified Substance Abuse Counselor" or as a "Certified Substance Abuse Prevention Consultant" if:

(1) The applicant is of good moral character.

(2) The applicant is not and has not engaged in any practice or conduct that would be grounds for disciplinary action under G.S. 90-113.44.

(3) The applicant is qualified for certification pursuant to the requirements of this Article and any rules adopted pursuant to it.

(4) The applicant has, at a minimum, a high school diploma or a high school equivalency certificate.

(5) The applicant has signed a form attesting to the intention to adhere fully to the ethical standards adopted by the Board.

(5a) The applicant submits a complete criminal history record check pursuant to G.S. 90-113.46A.

(6) The applicant has completed 270 hours of Board-approved education. The Board may prescribe that a certain number of hours be in a course of study for substance abuse counseling and that a certain number of hours be in a course of study for substance abuse prevention consulting. Independent study hours shall not compose more than fifty percent (50%) of the total number of hours required for initial credentialing.

(7) The applicant has documented completion of a minimum of 300 hours of Supervised Practical ~~Training and~~Training, has provided a Board-approved supervision contract between the applicant and an ~~approved supervisor.~~applicant supervisor, and has been deemed recommended by the applicant supervisor to advance in the credentialing process.

(8) The applicant for substance abuse counselor has completed ~~either~~ a total of 6,000 hours of supervised experience in the field, whether paid or ~~volunteer, or, if a graduate of a Board-approved master's degree program, a total of 3,000 hours of supervised experience in the field, whether paid or~~ volunteer. The applicant for substance abuse prevention consultant has completed a total of ~~10,000~~6,000 hours supervised experience in the field, whether paid or volunteer, or 4,000 hours if the applicant has at least a bachelors degree in a human services field from a regionally accredited college or university.

(9) The applicant has ~~successfully completed~~obtained a passing score on a written ~~examination and~~examination. An applicant for certification as a substance abuse counselor must also obtain a passing score on an oral examination promulgated and administered by the Board.

(b) The Board shall issue a certificate certifying an individual as a "Certified Clinical Supervisor" if, in addition to meeting the requirements of subdivisions (a)(1) through (5) of this section, the applicant:

(1) Submits proof of designation by the Board as a clinical supervisor intern.

(2) Prior to June 30, 1998, the applicant presents proof that the applicant has 12,000 hours experience in alcohol and drug abuse counseling and a bachelors degree or 8,000 hours experience in alcohol and drug abuse counseling and a minimum of a master's degree. After June 30, 1998, the applicant shall present proof that the applicant has a minimum of a master's degree in a human services field with a clinical application from a regionally accredited college or university.

(3) Has 6,000 hours experience as a substance abuse clinical supervisor if the applicant has a bachelors degree or 4,000 hours experience if the applicant has a master's degree in a human services field with a clinical application from a regionally accredited college or university.

(4) Has 30 hours of substance abuse clinical supervision specific education or training. These hours shall be reflective of the ~~12 core functions~~Twelve Core Functions in the applicant's clinical application and practice and may also be counted toward the applicant's ~~recertification~~ renewal as a substance abuse ~~counselor~~counselor or a clinical addictions specialist.

(5) Submits a letter of reference from a professional who can attest to the applicant's supervisory competence and two letters of reference from either counselors who have been supervised by the applicant or professionals who can attest to the applicant's competence.

(5a) Submits a complete criminal history record check pursuant to G.S. 90-113.46A.

(6) ~~Successfully completes~~Obtains a passing score on a written examination administered by the Board.

A person who practices as a certified clinical supervisor in addition to practicing as a certified substance abuse counselor shall be exempt from the practice supervision contract requirement.

(b1) The Board shall designate an applicant as a "Clinical Supervisor Intern" if, in addition to meeting the requirements of subdivisions (a)(1) through ~~(5)~~(5a) of this section, the applicant meets the following qualifications:

(1) Submits an application, resume, and official transcript showing that the applicant has obtained a master's degree in a human services field with a clinical application from a regionally accredited college or university.

(2) Submits verification statements.

(3) Submits proof of ~~certification~~ credentialing as a certified substance abuse ~~counselor or a certified~~counselor, a licensed clinical addictions ~~specialist.~~specialist, or certification or licensure through an organization granted deemed status by the Board.

(4) Submits documentation establishing that the applicant has completed at least fifty percent of the required clinical supervision specific training hours as defined by the Board.

(c) The Board shall issue a ~~certificate certifying~~license credentialing an applicant as a "~~Certified~~ Licensed Clinical Addictions Specialist" if, in addition to meeting the requirements of subdivisions (a)(1) through ~~(5)~~(5a) of this section, the applicant meets one of the following criteria:

(1) Criteria A. – The applicant:

a. Has a minimum of a master's degree with a clinical application in a human services field from a regionally accredited college or university.

b. Has two years postgraduate supervised substance abuse counseling experience.

c. Submits three letters of reference from ~~certified~~ licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

d. Has achieved a combined score set by the Board on a master's level written and oral examination administered by the Board.

e. Has attained 180 hours of substance abuse specific training ~~as described~~from either a regionally accredited college or university, which may include unlimited independent study, or from training events of which no more than fifty percent (50%) shall be in independent study. All hours shall be credited according to the standards set forth in G.S. 90-113.41A.

f. The applicant has documented completion of a minimum of 300 hours of supervised practical training and has provided a Board-approved supervision contract between the applicant and an ~~approved~~ applicant supervisor.

(2) Criteria B. – The applicant:

a. Has a minimum of a master's degree with a clinical application in a human services field from a regionally accredited college or university.

b. Has been certified as a substance abuse counselor.

c. Has one year of postgraduate supervised substance abuse counseling experience.

d. Has achieved a passing score on a master's level written examination administered by the Board.

e. Submits three letters of reference from ~~certified~~ either licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

(3) Criteria C. – The applicant:

a. Has a minimum of a master's degree in a human services field with both a clinical application and a substance abuse specialty from a regionally accredited college or university that includes 180 hours of substance abuse specific education and training pursuant to G.S. 90-113.41A.

b. Has one year of postgraduate supervised substance abuse counseling experience.

c. Has achieved a passing score on an oral examination administered by the Board.

d. Submits three letters of reference from ~~certified~~ licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

(4) Criteria D. – The applicant has a substance abuse certification from a professional discipline that has been granted deemed status by the Board.

(d) The Board shall issue a certificate certifying an applicant as a "Substance Abuse ~~Certified~~ Residential Facility Director" ~~if, in addition to meeting the requirements of subdivisions (a)(1) through (5) of this section,~~ if the applicant:

(1) Has been ~~certified~~ credentialed as a substance abuse counselor or a clinical addictions specialist.

(2) Has 50 hours of Board approved academic or didactic management specific training or a combination thereof. Independent study may compose up to fifty percent (50%) of the total number of hours required for initial credentialing.

(3) Submits letters of reference from the applicant's current supervisor and a colleague or coworker.

(d1) The Board shall issue a certificate certifying an applicant as a 'Certified Criminal Justice Addictions Professional', with the acronym 'CCJP', if in addition to meeting the requirements of subdivisions (a)(1) through (5a) of this section, the applicant:

(1) Has attained 270 hours of Board-approved education or training, unless the applicant has attained a minimum of a masters degree with a clinical application and a substance abuse specialty from a regionally accredited college or university whereby the applicant must only obtain 180 hours. The hours of education shall be specifically related to the knowledge and skills necessary to perform the tasks within the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated 'IC&RC/AODA, Inc.' criminal justice addictions professional performance domains as they relate to both adults and juveniles. Independent study may compose up to fifty

percent (50%) of the total number of hours obtained for initial certification or renewal.

(2) Has documented 300 hours of Board-approved supervised practical training. This supervision shall mean the administrative, clinical, and evaluative process of monitoring, assessing, and enhancing professional performance. A minimum of 10 hours of supervision in each criminal justice domain established by the IC&RC/AODA, Inc. is required.

(3) Has provided documentation of supervised work experience providing direct service to clients or offenders involved in one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections. The applicant must meet one of the following criteria:

a. Criteria A. – In addition to having a high school degree or GED, the applicant has a minimum of 6,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services that have been obtained during the past 10 years.

b. Criteria B. – In addition to having an associate degree, the applicant has a minimum of 5,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services obtained during the past 10 years.

c. Criteria C. – In addition to having at least a bachelors degree, the applicant has a minimum of 4,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services and this experience has been obtained during the past 10 years.

d. Criteria D. – In addition to having at least a masters degree in a human services field, the applicant has a minimum of 2,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services that has been obtained during the past 10 years.

e. Criteria E. – In addition to having at least a masters degree in a human services field with a specialty from a regionally accredited college or university that includes 180 hours of substance abuse specific education or training, the applicant has a minimum of 2,000 hours of postgraduate supervised substance abuse counseling experience.

f. Criteria F. – In addition to having obtained the credential of a certified clinical addictions specialist or other advanced credential in a human services field from an organization that has obtained deemed status with the Board, the applicant has a minimum of 1,000 hours of documented work experience in

direct services in criminal justice or addictions services that has been obtained during the past 10 years.

(4) Has passed the IC&RC/AODA, Inc. certified criminal justice addictions professional written examination.

(e) The Board shall publish from time to time information in order to provide specifics for potential applicants of an acceptable educational curriculum and the terms of acceptable supervised fieldwork experience.

(f) ~~Effective until January 1, 2001, any person who is certified as a certified clinical supervisor or who functions by his or her job description as a certified clinical supervisor shall be qualified to supervise applicants for certified clinical supervisor.~~

~~Effective from January 1, 2001 until January 1, 2003, only a person who is certified both as a certified clinical supervisor and as a certified clinical addictions specialist shall be qualified to supervise applicants for certified clinical addictions specialist, but a person who is certified as a certified clinical supervisor or a certified clinical addictions specialist shall be qualified to supervise an applicant for certification as a certified substance abuse counselor.~~

Effective January 1, 2003, only a person who is certified as a certified clinical supervisor or a clinical supervisor intern shall be qualified to supervise applicants for certified clinical supervisor and certified substance abuse counselor and applicants for ~~certified~~ licensed clinical addictions specialist who meet the qualifications of their credential other than through deemed status as provided in G.S. 90-113.40(c)(4).

"**§ 90-113.40A. Requirements for registration.**

(a) Upon application and payment of the required fee, the Board shall issue a registration designating an applicant as a registrant if the applicant:

(1) Provides documentation that he or she has received a high school diploma, or the equivalent, and evidence of any baccalaureate or advanced degrees the applicant has received.

(2) Completes a registration application on a form provided by the Board.

(3) Provides documentation of three hours of educational training in ethics.

(4) Signs a form attesting to the applicant's commitment to adhere to the ethical standards adopted by the Board.

(4a) Provides a complete criminal history record check pursuant to G.S. 90-113.46A.

(5) Signs a supervision contract provided by the Board that documents the proposed supervision process by an ~~approved~~ applicant supervisor.

(b) Registrant status shall be maintained for a period of up to five years while the registrant is in the process of completing his or her requirements for ~~certification~~ credentials pursuant to this Article. If at the end of a five-year period a registrant has not obtained ~~certification~~ a credential under this Article, the Board shall renew the registration for up to an additional five-year period after the registrant pays the required fee and complies with all requirements for registration pursuant to G.S. 90-113.40A. The Board shall terminate the registration of any registrant who fails to renew his or her registration.

(c) The registrant shall notify the Board of any criminal conviction imposed during the period of registration.

"§ 90-113.40B. ~~Approved~~ Applicant supervision.

The Board shall designate a person as an ~~approved~~ applicant supervisor of individuals applying for ~~registration or certification~~registration, certification, or licensure as a substance abuse professional as follows:

(1) A certified clinical supervisor shall supervise a clinical supervisor intern.

(2) A certified clinical supervisor or a clinical supervisor intern shall supervise a substance abuse residential facility director applicant, a clinical addictions specialist applicant, or a substance abuse counselor applicant.

~~(3) A certified clinical supervisor, a clinical supervisor intern, a certified clinical addictions specialist, or a certified substance abuse counselor shall supervise a registrant who provides DWI assessments.~~

(4) A certified substance abuse prevention consultant with a minimum of three years of professional experience, a certified clinical supervisor, or a clinical supervisor intern shall supervise a registrant applying for certification as a prevention consultant.

(5) Pursuant to the deemed status procedure under G.S. 90-113.41A, the supervision requirements described in subdivisions (1) through (4) of this section shall not apply to persons applying for ~~certification~~ licensure as a ~~certified~~ licensed clinical addictions specialist.

(6) A criminal justice addictions professional applicant shall be supervised by a certified clinical supervisor or clinical supervisor intern.

"§ 90-113.41. Examination.

(a) Except for those individuals applying for ~~certification~~ licensure under G.S. 90-113.41A, applicants for certification or licensure under this Article shall file an application at least 60 days prior to the date of examination and upon the forms and in the manner prescribed by the Board. The application shall be accompanied by the appropriate fee. No portion of this fee is refundable. Applicants who fail an examination may apply for reexamination upon the payment of another examination fee.

(b) Each applicant for certification or licensure under this Article shall be ~~examined~~ tested in an examination ~~that is consistent with the examination requirements of~~developed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated and the standards adopted by professional disciplines granted deemed status or their successor organizations.

(c) Applicants for certification or licensure shall be examined at a time and place and under the supervision that the Board determines. Examinations shall be given in this State at least twice each year.

(d) Applicants may obtain their examination scores and may review their examination papers in accordance with rules the Board adopts and agreements between Board-authorized test development companies.

"§ 90-113.41A. Deemed status.

(a) To be granted deemed status by the Board, a credentialing body of a professional discipline or its designee shall demonstrate that its substance abuse ~~certification~~ credentialing program substantially meets the following:

(1) Each person to whom the credentialing body awards credentials following the effective date of this act meets and maintains minimum requirements in substance abuse specific content areas. Each person also has a minimum of a master's degree with a clinical application in a human services field.

(2) The body requires 180 hours, or the equivalent thereof, of substance abuse specific education and training that covers the following content areas:

a. Basic addiction and cross addiction Physiology and Pharmacology of Psychoactive drugs that are abused.

b. Screening, assessment, and intake of clients.

c. Individual, group, and family counseling.

d. Treatment, planning, reporting, and record keeping.

e. Crisis intervention.

f. Case management and treatment resources.

g. Ethics, legal issues, and confidentiality.

h. Psychological, emotional, personality, and developmental issues.

i. ~~Coexisting~~ Co-occurring physical and mental disabilities.

j. Special population issues, including age, gender, race, ethnicity, and health status.

k. Traditions and philosophies of recovery treatment models and support groups.

(3) The program requires one year or its equivalent of post-degree supervised clinical substance abuse practice. At least fifty percent (50%) of the practice shall consist of direct substance abuse clinical care.

(b) The professional discipline seeking deemed status shall require its members to adhere to a code of ethical conduct and shall enforce that code with disciplinary action.

(c) The Board may grant deemed status to any professional discipline that substantially meets the standards in this section. Once such status has been granted, an individual within the professional discipline may apply to the Board for ~~certification as a certified clinical addictions specialist.~~the credential of licensed clinical addictions specialist.

(d) The Standards ~~and Credentialing~~ Committee of the Board shall review the standards of each professional discipline every third year from the date it was granted deemed status to determine if the discipline continues to substantially meet the requirements of this section. If the Committee finds that a professional discipline no longer meets the requirements of this section, it shall report its findings to the Board at the Board's next regularly scheduled meeting. The deemed status standing of a

professional discipline's credential may be discontinued by a two-thirds vote of the Board.

"§ 90-113.41B. Change of name or address.

Every person licensed, ~~certified~~ certified, or registered under the provisions of this Article shall give written notice to the Board of any change in his or her name or address within 60 business days after the change takes place.

"§ 90-113.42. ~~Exemptions.~~Violations; exemptions.

(a) It shall be unlawful for any person not licensed or otherwise credentialed as a substance abuse professional pursuant to this Article to engage in those activities set forth in the scope of practice of a substance abuse professional under G.S. 90-113.31B, unless that person is regulated by another profession or is a registrant or intern as defined by this Article.

(b) It is not the intent of this Article to regulate members of other regulated professions who provide substance abuse services or consultation in the normal course of the practice of their profession. ~~Accordingly, this~~

(c) This Article does not apply to any person registered, certified, or licensed by the State or federal government to practice any other occupation or profession while rendering substance abuse services or consultation in the performance of the occupation or profession for which the person is registered, certified, or licensed.

(d) Only individuals ~~certified~~ registered, certified, or licensed under this Article may use the title ~~certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director.~~'Certified Substance Abuse Counselor', 'Certified Substance Abuse Prevention Consultant', 'Certified Clinical Supervisor', 'Licensed Clinical Addictions Specialist', 'Certified Substance Abuse Residential Facility Director', 'Certified Criminal Justice Addictions Professional', 'Substance Abuse Counselor Intern', 'Clinical Addictions Specialist Intern', 'Clinical Supervisor Intern', or 'Registrant'.

"§ 90-113.43. Illegal practice; misdemeanor penalty.

Except as otherwise authorized in this Article, no person shall:

(1) ~~Practice,~~Offer substance abuse professional services, practice, attempt to practice, or supervise while holding himself or herself out to be a certified ~~substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director~~substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified or licensed clinical addictions specialist, clinical addictions specialist intern, substance abuse residential facility director, certified criminal justice addictions professional, clinical supervisor intern, substance abuse prevention consultant, or registrant without first having obtained a certificate of ~~certification~~ registration, certification, or licensure from the Board.

(2) Use in connection with any name any letters, words, numerical codes, or insignia indicating or implying that this person is a ~~certified~~

registrant, substance abuse counselor, ~~certified~~ substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ clinical addictions specialist, ~~or~~ certified substance abuse residential facility ~~director~~ director, substance abuse counselor intern, or clinical addictions specialist intern unless this person is ~~certified~~ registered, certified, or licensed pursuant to this Article.

(3) Practice or attempt to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ licensed clinical addictions specialist, certified criminal justice addictions professional, or certified substance abuse residential facility director with a revoked, lapsed, or suspended ~~certification.~~certification or license.

(4) Aid, abet, or assist any ~~uncertified~~ person to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ licensed clinical addictions specialist, ~~or~~ certified substance abuse residential facility ~~director~~ director, registrant, substance abuse counselor intern, clinical addictions specialist, or clinical supervisor intern in violation of this Article.

(5) Knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ licensed clinical addictions specialist, ~~or~~ certified substance abuse residential facility ~~director~~ director, substance abuse counselor intern, clinical addictions specialist intern, or clinical supervisor intern unless that person is ~~certified~~ registered, certified, or licensed under this Article.

(6) Repealed by S.L. 1997-492, s. 13.

(7) Practice, supervise, or attempt to practice or supervise or knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a designated substance abuse intern without being designated as such by the Board.

A person who engages in any of the illegal practices enumerated by this section is guilty of a Class 1 misdemeanor. Each act of unlawful practice constitutes a distinct and separate offense.

"§ 90-113.44. Grounds for disciplinary action.

(a) Grounds for disciplinary action for an applicant or credentialed professional include:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain ~~certification~~ licensure, certification, or registration or renewal of ~~certification~~ licensure, certification, or registration.

(2) The use of drugs or alcoholic beverages to the extent that professional competency is ~~affected, until proof of rehabilitation can be established.~~affected.

(2a) The use of drugs or alcoholic beverages to the extent that a substance abuse professional suffers impairment, including conviction of the offense of driving while impaired.

(3) Conviction of an offense under any municipal, State, or federal ~~narcotic or controlled substance law, until proof of rehabilitation can be established.~~law other than traffic laws as prescribed by Chapter 20 of the General Statutes.

(4) Conviction of a felony or other public offense involving moral ~~turpitude, until proof of rehabilitation can be established.~~turpitude. Conviction of a Class A-E felony shall result in an immediate suspension of ~~certification~~ licensure, certification, or registration for a minimum of one year.

(5) An adjudication of insanity or incompetency, until proof of recovery from this condition can be ~~established.~~established by a licensed psychologist or psychiatrist.

(6) Engaging in any act or practice in violation of any of the provisions of this Article or any of the rules adopted pursuant to it, or aiding, abetting, or assisting any other person in such a violation.

(7) The commission of an act of malpractice, gross negligence, or incompetence ~~in the practice of substance abuse counseling, substance abuse prevention consulting, clinical supervising, or in serving as a clinical addictions specialist, residential facility director, or a registrant.~~while serving as a substance professional, intern, or registrant.

~~(8) Practicing as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist or certified residential facility director without a valid certificate or practicing as a registrant without a valid registration.~~

(9) Engaging in conduct that could result in harm or injury to the public.

(10) Entering into a dual relationship that impairs professional judgment or increases the risk of exploitation with a client or supervisee.

(11) Practicing as a credentialed substance abuse professional outside of his or her scope of practice pursuant to G.S. 90-113.31B.

(b) Denial of an applicant's licensure, certification, or registration or the granting of licensure, certification, or registration on a probationary or other conditional status shall be subject to substantially the same rules and procedures prescribed by the Board for review and disciplinary actions against any person holding a license, certificate, or registration. A suspension of a credential resulting from relapse or impairment due to substance use, mental health, or medical disorder shall be imposed for at least six months beginning from the date of successful discharge from a residential substance abuse treatment program or other appropriate treatment modality determined as a result of an assessment by a Board-approved assessor. Disciplinary actions involving a clinical addictions specialist whose licensure is achieved through deemed status shall be initially

heard by the specialist's credentialing body. The specialist may appeal the body's decision to the Board. The Board shall, however, have the discretionary authority to hear the initial disciplinary action involving a credentialed professional.

"§ 90-113.45. Enjoining illegal practices.

(a) The Board may, if it finds that any person is violating any of the provisions of this Article or of the rules adopted pursuant to it, apply in its own name to the superior court for a temporary or permanent restraining order or injunction to restrain that person from continuing these illegal practices. The court may grant injunctive relief regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation. In the court's consideration of the issue of whether to grant or continue an injunction sought by the Board, a showing of conduct in violation of the terms of this Article shall be sufficient to meet any requirement of general North Carolina injunction law for irreparable damage.

(b) The venue for actions brought under this section is the superior court of any county in which the illegal acts are alleged to have been committed or in the county where the defendant resides.

"§ 90-113.46. Application of requirements of Article.

All persons ~~certified~~ credentialed by the North Carolina Substance Abuse Professional ~~Certification~~ Practice Board, Inc., as of July 1, 1994, shall be ~~certified~~ credentialed by the Board pursuant to this Article. All these persons are subject to all the other requirements of this Article and of the rules adopted pursuant to it.

"§ 90-113.46A. Criminal history record checks of applicants for registration, certification, or licensure.

(a) All applicants for registration, certification, or licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny registration, certification, or licensure to an applicant. The Board shall ensure that the State and national criminal history of an applicant is checked. The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, the fee required by the Department of Justice for providing this service, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) If an applicant's criminal history record check reveals one or more convictions as defined in G.S. 90-113.31A(14), the conviction shall not automatically bar issuance of a credential by the Board to the applicant. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.

(4) The circumstances surrounding the commission of the crime, if known.

(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.

(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(7) The subsequent commission by the person of a crime as defined in G.S. 90-113.31A(14).

If, after reviewing the factors, the Board determines that the grounds set forth in G.S. 90-113.44 exist, the Board may deny registration, certification, or licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(c) Limited Immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying registration, certification, or licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 2. Article 4 of Chapter 114 of the General Statutes is amended by adding the following new section to read:

"**§ 114-19.11A. Criminal record checks of applicants for registration, certification, or licensure as a substance abuse professional.**

The Department of Justice may provide to the North Carolina Substance Abuse Professional Practice Board from the State and National Repositories of Criminal Histories the criminal history of any applicant for registration, certification, or licensure pursuant to Article 5C of Chapter 90 of the General Statutes. Along with the request, the Board shall provide to the Department of Justice the fingerprints of the applicant, a form signed by the applicant consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 3. All members serving on the North Carolina Substance Abuse Professional Practice Board on the effective date of this act shall complete their current three-year terms. Upon completion of their terms, newly appointed or elected members of the Board shall serve four-year terms pursuant to G.S. 90-113.33, as enacted in Section 1 of this act.

SECTION 4. Notwithstanding G.S. 90-113.40(d1), as enacted by Section 1 of this act, the North Carolina Substance Abuse Professional Practice Board may certify a person as a certified criminal justice addictions professional during a limited period of 90 days from the date this act becomes effective and the credential is approved by the

IC&RC/AODA, Inc., if the applicant qualifies based on experience providing services to clients or offenders exhibiting substance abuse disorders and is working in a program determined by the Board to be integrally involved in at least one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections. In addition to meeting the requirements of G.S. 90-113.40(a)(1) through (5a), the person shall do the following:

(1) Provide two letters recommending certification from a current or former peer who functions in substantially the same professional capacity as determined by the Board.

(2) Provide one letter recommending certification from a person currently supervising or who has supervised the applicant within the previous five years attesting to the applicant's competency in the fields of substance abuse and criminal justice.

(3) Pay the criminal justice addictions professional certification fee for certification not to exceed one hundred fifty dollars ($150.00).

(4) Provide one of the following:

a. A high school diploma or a high school equivalency certificate, documentation of eight years or 16,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in at least one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

b. An associate degree and documentation of six years or 12,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

c. A bachelors degree in the Human Services field with four years or 8,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in at least one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

d. A masters degree or above in the Human Services field with two years or 4,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 705
PROPOSED COMMITTEE SUBSTITUTE S705-PCS55229-RR-15

Short Title: Amend NC Substance Abuse Act. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE LICENSURE OF SUBSTANCE ABUSE PROFESSIONALS, TO ESTABLISH THE CREDENTIAL OF CERTIFIED CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL, AND TO ALLOW THE DEPARTMENT OF JUSTICE TO CONDUCT CRIMINAL HISTORY RECORD CHECKS FROM STATE AND NATIONAL REPOSITORIES OF CRIMINAL HISTORY OF APPLICANTS FOR CREDENTIALS UPON THE REQUEST OF THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. Article 5C of Chapter 90 of the General Statutes reads as rewritten:

"Article 5C.

"North Carolina Substance Abuse ~~Professionals Certification~~Professional Practice Act.

"§ 90-113.30. Declaration of purpose.

The North Carolina Substance Abuse Professional ~~Certification~~ Practice Board, established by G.S. 90-113.32, is recognized as the ~~certifying~~ registering, certifying, and licensing authority for substance abuse professionals described in this Article in order to safeguard the public health, safety, and welfare, to protect the public from being harmed by unqualified persons, to assure the highest degree of professional care and conduct on the part of ~~certified~~ credentialed substance abuse professionals, to provide for the establishment of standards for the education of ~~certified~~ credentialed substance abuse professionals, and to ensure the availability of ~~certified~~ credentialed substance abuse professional services of high quality to persons in need of these services. It is the purpose of this Article to provide for the regulation of ~~Board-certified~~Board-credentialed persons offering substance abuse counseling services, substance abuse prevention services, or any other substance abuse services for which the Board may grant ~~certification.~~registration, certification, or licensure.

~~"§90-113.31. Definitions.~~

~~The following definitions shall apply in this Article:~~

~~(1) Approved supervisor. A person who provides supervision as required by the Board to persons applying for registration or certification as a substance abuse professional pursuant to this Article.~~

~~(1a) Board. The North Carolina Substance Abuse Professional Certification Board.~~

~~(1b) Certified clinical addictions specialist. A person certified by the Board to practice as a clinical addictions specialist in accordance with the provisions of this Article.~~

~~(1c) Certified clinical supervisor. A person certified by the Board to practice as a clinical supervisor in accordance with the provisions of this Article.~~

~~(1d) Certified residential facility director. A person certified by the Board to practice as a residential facility director in accordance with the provisions of this Article.~~

~~(2) Certified substance abuse counselor. A person certified by the Board to practice as a substance abuse counselor in accordance with the provisions of this Article.~~

~~(3) Repealed by S.L. 1997-492, s. 2.~~

~~(3a) Certified substance abuse prevention consultant. A person certified by the Board to practice substance abuse prevention in accordance with the provisions of this Article.~~

~~(4) Clinical supervisor intern. A person designated by the Board to practice as a clinical supervisor intern for a period not to exceed three years without a showing of good cause in accordance with the provisions of this Article.~~

~~(4a) Credentialing body. A board that licenses, certifies, or regulates a profession or practice.~~

~~(4b) Deemed status. Recognition by the Board of the credentials offered by a professional discipline whereby the individuals certified, licensed, or otherwise recognized by the discipline as having met the standards of a substance abuse specialist may apply individually for certification as a certified clinical addictions specialist.~~

~~(4c) Human services field. An area of study that focuses on the biological, psychological, and social aspects of human beings.~~

~~(4d) Repealed by Session Laws 1999-164, s. 1.~~

~~(5) Prevention. The reduction, delay, or avoidance of alcohol and of other drug use behavior. "Prevention" includes the promotion of positive environments and individual strengths that contribute to personal health and well-being over an entire life and the development of strategies that encourage individuals, families, and communities to take part in assessing and changing their lifestyle and environments.~~

~~(6) Professional discipline. — A field of study characterized by the technical, educational, and ethical standards of a profession.~~

~~(6a) Registrant. — A person who has initiated a certification process to become a certified substance abuse counselor or a certified clinical addictions specialist pursuant to this Article and is authorized to provide DWI assessments pursuant to G.S. 122C-142.1.~~

~~(7) Substance abuse counseling. — The assessment, evaluation, and provision of counseling to persons suffering from substance, drug, or alcohol abuse or dependency.~~

~~(7a) Substance abuse counselor intern. — A person who successfully completes 300 hours of Board approved supervised practical training and a written examination in pursuit of certification as a substance abuse counselor.~~

~~(8) Substance abuse professional. — A certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director.~~

"**§ 90-113.31A. Definitions.**

The following definitions shall apply in this Article:

(1) Applicant. – A person who has initiated a process to become a substance abuse professional pursuant to this Article.

(2) Applicant supervisor. – A person who provides supervision as required by the Board to persons applying for registration, certification, or licensure as a substance abuse professional pursuant to this Article.

(3) Board. – The North Carolina Substance Abuse Professional Practice Board.

(4) Certified clinical supervisor. – A person certified by the Board to practice as a clinical supervisor in accordance with the provisions of this Article.

(5) Certified criminal justice addictions professional. – A person certified by the Board to practice as a criminal justice addictions professional who under supervision provides direct services to clients or offenders exhibiting substance abuse disorders and works in a program determined by the Board to be involved in a criminal justice setting.

(6) Certified substance abuse counselor. – A person certified by the Board to practice under the supervision of a practice supervisor as a substance abuse counselor in accordance with the provisions of this Article.

(7) Certified substance abuse prevention consultant. – A person certified by the Board to practice substance abuse prevention in accordance with the provisions of this Article.

(8) Certified substance abuse residential facility director. – A person certified by the Board to practice as a substance abuse residential facility director in accordance with the provisions of this Article.

(9) Clinical addictions specialist intern. – A person who successfully completes 300 hours of Board-approved supervised practical training and passes a written examination in pursuit of licensure as a clinical addictions specialist.

(10) Clinical supervisor intern. – A person designated by the Board to practice as a clinical supervisor under the supervision of a certified clinical supervisor for a period not to exceed three years without a showing of good cause in accordance with the provisions of this Article.

(11) Counseling. – The utilization of special skills to assist individuals, families, or groups in achieving objectives, including the following:

a. Exploring a problem and its ramifications.

b. Examining attitudes and feelings.

c. Considering alternative solutions.

d. Decision making.

(12) Credential. – Any registration, certification, or license issued by the Board.

(13) Credentialing body. – A board that licenses, certifies, registers, or otherwise regulates a profession or practice.

(14) Criminal history. – A history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice substance abuse professional services. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to

underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(15) Deemed status. – Recognition by the Board of the credentials offered by a professional discipline whereby the individuals certified, licensed, or otherwise recognized by the discipline as having met the standards of a clinical addictions specialist may apply individually for licensure as a licensed clinical addictions specialist.

(16) Dual relationship. – A relationship in addition to the professional relationship with a person to whom the substance abuse professional delivers services in the Twelve Core Functions or the performance domains, both as defined in rules adopted by the Board, or as provided in a supervisory capacity. These relationships may result in grounds for disciplinary action.

(17) Human services field. – An area of study that focuses on the biological, psychological, behavioral, and social aspects of human welfare with focus on the direct services designed to improve it.

(18) Independent study. – Any course of study that is not traditional classroom-based that must be preapproved by the Board or any organization that has deemed status with the Board.

(19) Licensed clinical addictions specialist. – A person licensed by the Board to practice as a clinical addictions specialist in accordance with the provisions of this Article.

(20) Practice supervisor. – A certified clinical supervisor, clinical supervisor intern, or licensed clinical addictions specialist who provides oversight and responsibility in a face-to-face capacity for each certified substance abuse counselor or criminal justice addictions professional.

(21) Prevention. – The reduction, delay, or avoidance of alcohol and of other drug use behavior. 'Prevention' includes the promotion of positive environments and individual strengths that contribute to personal health and well-being over an entire life and the development of strategies that encourage individuals, families, and communities to take part in assessing and changing their lifestyle and environments.

(22) Professional discipline. – A field of study characterized by the technical, educational, and ethical standards of a profession.

(23) Registrant. – A person who completes all requirements to be registered with the Board and is supervised by a certified clinical supervisor or clinical supervisor intern.

(24) Substance abuse counseling. – The assessment, evaluation, and provision of counseling and therapeutic service to persons suffering from substance abuse or dependency.

(25) Substance abuse counselor intern. – A person who successfully completes 300 hours of Board-approved supervised practical training

and passes a written examination in pursuit of credentialing as a substance abuse counselor.

(26) Substance abuse professional. – A registrant, certified substance abuse counselor, substance abuse counselor intern, certified substance abuse prevention consultant, certified clinical supervisor, clinical addictions specialist intern, licensed clinical addictions specialist, certified substance abuse residential facility director, or certified criminal justice addictions professional.

"**§ 90-113.31B. Scope of practice.**

The scope of practice is the use by all substance abuse professionals and their ongoing supervisees of principles, methods, and procedures of the Twelve Core Functions or performance domains as prescribed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated, and as limited by individual credential and supervisory requirements pursuant to this Article. Specifically, the scope of practice for each individual defined as a substance abuse professional under G.S. 90-113.31A is as follows:

(1) The practice of a certified substance abuse counselor consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, and referral to treat addictive disorder or disease and help prevent relapse.

(2) The practice of a certified substance abuse prevention consultant is based on knowledge in the performance domains to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease and help prevent relapse.

(3) The practice of a certified clinical supervisor is based on knowledge in the performance domains to supervise substance abuse professionals who work to treat, prevent, or reduce the conditions that place individuals at risk of developing addictive disorder or disease and help prevent relapse.

(4) The practice of a licensed clinical addictions specialist may be independent and consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, referral to reduce the conditions that place individuals at risk of developing addictive disorder or disease with co-occurring disorders, and treatment for addictive disorder or disease. The licensed clinical addictions specialist may provide supervision to maintain a professional credential as defined by this Article.

(5) The practice of a certified substance abuse residential facility director is a voluntary credential and consists of the Twelve Core Functions,

including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with professionals in regard to client treatment and services, referral to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease, treatment for addictive disorder or disease, and the prevention of relapse as well as academic management training.

(6) The practice of a certified criminal justice addictions professional is based on knowledge in the performance domains of dynamics of addiction in criminal behavior; legal, ethical, and professional responsibility; criminal justice system and processes; screening, intake, and assessment; case management; monitoring; and client supervision and counseling to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease, treat addictive disorder or disease, and help prevent relapse.

"**§ 90-113.32. Board; composition; voting.**

(a) The Board is created as the ~~certifying~~ authority ~~for substance abuse counselors, substance abuse prevention consultants, clinical supervisors, clinical addictions specialists, and residential facility directors~~to credential substance abuse professionals in North Carolina.

(b) Until the full Board is elected or appointed pursuant to subsection (c) of this section, the Board shall consist of 16 members with one member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121, and one member appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. The remaining 14 shall be those members of the current North Carolina Substance Abuse Professional ~~Certification~~ Practice Board, Inc., who have terms that are unexpired as of the effective date of this Article. The initial Board shall appoint an initial Nominating and Elections Committee to fill immediate vacancies on the Board, using the process established in subsection (d) of this section. The election and appointment process of the initial Board shall result in a Board of 19 members by April 1, 1995. As these initial members' terms expire, their successors shall be appointed as described in subsection (c) of this section, until the permanent Board is established, as described in subsection (c) of this section. Time spent as an initial member counts in determining the limitation on consecutive terms prescribed in subsection (e) of this section.

(c) After the initial Board members' terms expire, the Board shall consist of the following members, all of whom shall reside in North Carolina, appointed or elected as follows:

(1) Eleven professionals ~~certified~~ credentialed pursuant to this Article and elected by the ~~certified~~ credentialed professionals, at least two of whom shall serve each of the four Division of Mental Health,

Developmental Disabilities, and Substance Abuse Services regions of the State. Three members shall serve as members at large.

(2) Three members at large chosen from laypersons or other professional disciplines who have shown a special interest in the field of substance abuse, nominated by the Nominating and Elections Committee established by subsection (d) of this section and elected by the Board.

(3) Two members from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, appointed by the Chief of ~~Substance Abuse Services Section, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services,~~the North Carolina Substance Abuse Single State Agency, at least one of whom ~~is from the Substance Abuse Services Section.~~administers substance abuse services.

(4) One member of the public at large appointed by the Governor.

(5) One member of the public at large appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121 and one member of the public at large appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121.

(6) One member shall represent each of the professional disciplines granted deemed status under G.S. 90-113.41A. The member may be appointed by the professional discipline on or before a date set by the Board. If the professional discipline has at least one association in the State, the member shall be chosen from a list of nominees submitted to the association. The members appointed or elected under this subdivision shall be certified as substance abuse specialists by the professional discipline that the members represent.

No member of the General Assembly shall serve on the Board.

(c1) Every member of the Board shall have the right to vote on all matters before the Board, except for the President who shall vote only in case of a tie or when another member of the Board abstains on the question of whether the professional discipline the member represents shall retain its deemed status.

(d) The Board shall appoint five professionals from the field of substance abuse counseling and substance abuse prevention consulting to serve on the Nominating and Elections Committee. Of these five, at least three shall not be members of the Board. The Board shall appoint a member of the Nominating and Elections Committee to serve as chair. The Committee's purpose is to accept nominations from professionals certified or licensed by the Board to fill vacancies on the Board in membership categories prescribed by subdivisions (1) and (2) of subsection (c) of this section and to conduct the election of Board members. The Committee shall solicit nominations from all professionals it has certified or licensed under this Article when elected members' terms are due to expire. The certified or licensed professionals shall submit to the Committee

all nominations beginning 90 days and ending ~~14~~ 28 days before the election of new Board members. The Committee shall furnish all certified or licensed professionals with a ballot containing all the nominees for each elected Board member vacancy. In soliciting and making nominations for this process, the Committee shall give consideration to factors that promote representation on the Board by professionals certified or licensed by the Board. The Committee shall serve for a two-year term, its successors to be appointed for the same term by the Board.

(e) Members of the Board shall serve for ~~three-year~~four-year terms. No Board member shall serve for more than two consecutive terms, but a person who has been a member for two consecutive terms may be reappointed after being off the Board for a period of at least one year. When a vacancy occurs in an unexpired term, the Board shall, as soon as practicable, appoint temporary members to serve until the end of the unexpired terms. Time spent as a temporary member does not count in determining the limitation on consecutive terms.

(f) If a member becomes ineligible to serve on the Board for any reason, except when the member has committed an ethical violation that results in the suspension or revocation of the member's professional credentials, ~~the~~ that member may fulfill the remainder of ~~the member's~~his or her term on the Board.

"§ 90-113.33. Board; powers and duties.

The Board shall:

(1) Examine and determine the qualifications and fitness of applicants for certification and licensure to practice in this State.

(1a) Determine the qualifications and fitness of organizations applying for deemed status.

(2) Issue, renew, deny, suspend, or revoke ~~certification~~ licensure, certification, or registration to practice in this State or reprimand or otherwise discipline ~~certificate~~ a license, certificate, or registration ~~holders~~ holder in this State. ~~Denial of an applicant's certification or registration or the granting of certification or registration on a probationary or other conditional status shall be subject to substantially the same rules and procedures prescribed by the Board for review and disciplinary actions against those persons holding certificates or registrations. Disciplinary actions involving a clinical addictions specialist whose certification is achieved through deemed status shall be initially heard by the specialist's credentialing body. The specialist may appeal the body's decision to the Board. The Board shall, however, have the authority to hear the initial disciplinary action involving a clinical addictions specialist.~~

(3) Deal with issues concerning reciprocity.

(4) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining exists.

(5) Employ ~~the professional and clerical~~and fix the compensation of personnel and legal counsel that the Board determines is necessary to carry out the provisions of this Article. The Board's employment of

legal counsel is subject to the provisions of G.S. 114-2.3. The Board may purchase or rent necessary office space, equipment, and supplies.

(6) Conduct administrative hearings in accordance with Chapter 150B of the General Statutes when a "contested case", as defined in Chapter 150B, arises.

(7) Appoint from its own membership one or more members to act as representatives of the Board at any meeting in which it considers this representation is desirable.

(8) Establish fees for applications for examination, registration, certificates of ~~certification~~ certification, licensure, and renewal, and other services provided by the Board.

(9) Adopt any rules necessary to carry out the purpose of this Article and its duties and responsibilities pursuant to this Article.

(10) Request that the Department of Justice conduct criminal history record checks of applicants for registration, certification, or licensure pursuant to G.S. 114-19.11A.

The powers and duties enumerated in this section are granted for the purposes of enabling the Board to safeguard the public health, safety, and welfare against unqualified or incompetent practitioners and are to be liberally construed to accomplish this objective. When the Board exercises its authority under this Article to discipline a person, it may, as part of the decision imposing the discipline, charge the costs of investigations and the hearing to the person disciplined.

"§ 90-113.33A. Officers may administer oaths, and subpoena witnesses, records, and other materials.

The President or other presiding officer of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and may summon and issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board. The Board may order that any client records, documents, or other materials concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection, notwithstanding any other provisions of law providing for the application of any counselor-client or physician-patient privilege with respect to such records, documents, or other materials. All records, documents, or other materials compiled by the Board are subject to the provisions of G.S. 90-113.34, except that in any proceeding before the Board, record of any hearing before the Board, and notice of charges against any person ~~certified~~ credentialed by the Board, the Board shall withhold from public disclosure the identity of a client, including information relating to dates and places of treatment, or any other information that tends to identify the client unless the client or the client's representative has expressly consented to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence sought does not relate to a matter in issue, the subpoena does not describe the evidence with sufficient particularity, or the subpoena is invalid.

"§ 90-113.34. Records to be kept; copies of records.

(a) The Board shall keep a regular record of its proceedings, together with the names of the members of the Board present, the names of the applicants for registration, certification, and licensure as well as other information relevant to its actions. The Board shall cause a record to be kept that shall show the name, last known place of business, last known place of residence, and date and number of the ~~certificate of certification as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director for every living certified person.~~credential assigned to each substance abuse professional meeting the standards set forth in this Article. Any interested person in the State is entitled to obtain a copy of ~~that record on~~Board records upon application to the Board and ~~upon~~ payment of a reasonable charge that is based on the costs involved in providing the copy.

(b) The Board may in a closed session receive evidence regarding the provision of substance abuse counseling or other treatment and services provided to a client who has not expressly or through implication consented to the public disclosure of such treatment as may be necessary for the protection of the rights of the client or of the accused registrant or substance abuse professional and the full presentation of relevant evidence. All records, papers, and other documents containing information collected and compiled by the Board, its members, or employees as a result of investigations, inquiries, or interviews conducted in connection with ~~a certification~~awarding a credential or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes, except any notice or statement of charges, or notice of hearing shall be a public record notwithstanding that it may contain information collected and compiled as a result of an investigation, inquiry, or interview. If any record, paper, or other document containing information collected and compiled by the Board as provided in this subsection is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record.

(c) Notwithstanding any provision to the contrary, the Board may, in any proceeding, record of any hearing, and notice of charges, withhold from public disclosure the identity of a client who has not expressly or through implication consented to such disclosure of treatment by the accused substance abuse professional.

"**§ 90-113.35. Disposition of funds.**

All fees and other moneys collected and received by the Board shall be used to implement this Article. The financial records of the Board shall be subjected to an annual audit and paid for out of the funds of the Board.

"**§ 90-113.36. ~~Certificates of certification.~~Credentials.**

(a) The Board shall furnish a certificate of certification or licensure to each applicant successfully completing the requirements for ~~certification.~~his or her credential.

(b) The Board may furnish a certificate of certification or licensure to any person in another state or territory if the individual's qualifications were, at the date of ~~registration or~~registration, certification, or licensure, substantially equal to the requirements under this Article. However, an out-of-state applicant shall first file application and pay any required fees.

~~"§ 90-113.37. Renewal of certification; lapse; revival.~~

~~(a) Every person certified pursuant to this Article who desires to maintain certification status shall apply to the Board for a renewal of certification every other year and pay to the secretary-treasurer the prescribed fee. Renewal of certification is subject to completion of no more than 60 hours of those continuing education requirements established by the Board. A clinical supervisor shall complete 15 hours of substance abuse clinical supervision training prior to the certificate being renewed. Certification that is not renewed automatically lapses, unless the Board provides for the late renewal of certification upon the payment of a late fee. No late renewal shall be granted more than five years after a certification expires. A suspended certification is subject to this section's renewal requirements and may be renewed as provided in this section. This renewal does not entitle the certified person to engage in the certified activity or in any other conduct or activity in violation of the order or judgment by which the certification was suspended, until the certification is reinstated. If a certification revoked on disciplinary grounds is reinstated and requires renewal, the certified person shall pay the renewal fee and any applicable late fee.~~

~~(b) The Board shall establish the manner in which lapsed certification may be revived or extended.~~

"§ 90-113.37A. Renewal of credential; lapse.

(a) Every person credentialed pursuant to this Article who desires to maintain his or her credentials shall apply to the Board for a renewal of certification or licensure every other year and pay to the treasurer the prescribed fee.

(b) Renewal of licensure is subject to completion of at least 40 hours of the continuing education requirements established by the Board. Renewal of substance abuse counselor or substance abuse prevention consultant certification is subject to completion of at least 60 hours of the continuing education requirements established by the Board. A certified substance abuse counselor shall submit a Board-approved supervision contract signed by the applicant and a practice supervisor documenting ongoing supervision at a ratio of one hour of supervision to every 40 hours of practice after certification is granted by the Board on a form provided by the Board. Any person certified by the Board as a certified alcoholism counselor or certified drug abuse counselor shall become a certified substance abuse counselor.

A clinical supervisor shall complete at least 15 hours of substance abuse clinical supervision training prior to the certificate being renewed. A substance abuse residential facility director shall complete at least 10 hours of substance abuse training for renewal. A certified criminal justice addictions professional shall complete at least 40 hours of continuing education that must be earned in the certified criminal justice addictions professional performance domains. A certified criminal justice addictions professional shall submit a Board-approved supervision contract signed by the criminal justice addictions professional and a practice supervisor documenting ongoing supervision at a ratio of one hour of supervision to every 40 hours of practice after certification is granted by the Board on a form provided by the Board.

(c) Independent study hours shall compose no more than fifty percent (50%) of the total number of hours required for renewal.

(d) A credential that is not renewed automatically lapses, unless the Board approves the late renewal of a credential upon the payment of a late fee.

(e) No late renewal shall be granted more than five years after a certification or licensure expires.

(f) A suspended credential may be renewed as provided in this section. This renewal does not entitle the credentialed person to engage in conduct or activity in violation of the order or judgment by which the credential was suspended, until the credential is reinstated. If a credential revoked on disciplinary grounds is reinstated and requires renewal, the credentialed person shall pay the renewal fee and any applicable late fee.

(g) The Board shall establish the manner in which lapsed certification or licensure may be revived or extended.

"§ 90-113.38. Maximums for certain fees.

(a) The fee to obtain a certificate of certification as a substance abuse counselor, substance abuse prevention consultant, clinical supervisor, ~~or~~ substance abuse residential facility ~~director~~ director, or certified criminal justice addictions professional may not exceed four hundred seventy-five dollars ($475.00). The fee to renew a certificate may not exceed one hundred fifty dollars ($150.00).

(b) The fee to obtain a certificate of ~~certification~~ licensure for a clinical addictions specialist pursuant to deemed status ~~may~~ shall not exceed one hundred fifty dollars ($150.00). The fee to renew a ~~certificate may~~license for a clinical addictions specialist pursuant to deemed status shall not exceed one hundred dollars ($100.00). The fee to obtain a ~~certificate of certification~~license for a clinical addictions specialist pursuant to all other procedures authorized by this Article ~~may~~ shall not exceed four hundred seventy-five dollars ($475.00). The fee to renew the ~~certificate may~~license shall not exceed one hundred fifty dollars ($150.00).

(b1) The fee to obtain a registration as a registrant shall ~~be~~ not exceed one hundred fifty dollars ($150.00). The fee to renew a registration shall ~~be~~ not exceed one hundred fifty dollars ($150.00).

(c) There shall be a reexamination fee of one hundred fifty dollars ($150.00) which shall be paid for each reexamination in addition to the fees ~~required under~~authorized pursuant to subsection (a) of this section. There shall be a fee not to exceed twenty-five dollars ($25.00) for rescheduling any examination.

(d) There shall be a fee ~~of~~ not to exceed twenty-five dollars ($25.00) to obtain a written verification ~~of certification~~or additional copy of a credential issued by the Board.

(e) There shall be a late renewal fee not to exceed one hundred twenty-five dollars ($125.00).

(f) In addition to any other prescribed fees, the Board shall charge a fee not to exceed one hundred fifty dollars ($150.00) for each administration of the test an applicant must pass to be credentialed as a United States Department of Transportation substance abuse professional.

"§ 90-113.39. Standards for ~~certification.~~credentials.

The Board shall establish standards ~~for certification of~~to credential substance abuse professionals. The ~~certification~~ credentialing standards of the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated and the standards adopted by professional disciplines granted deemed status or their successor organizations may be used as guidelines for the Board's standards. The Board shall publish these required ~~standards separately from its rules so as to provide easy access to the~~ standards.

"§ 90-113.40. Requirements for ~~certification.~~certification and licensure.

(a) The Board shall issue a certificate certifying an applicant as a "Certified Substance Abuse Counselor" or as a "Certified Substance Abuse Prevention Consultant" if:

(1) The applicant is of good moral character.

(2) The applicant is not and has not engaged in any practice or conduct that would be grounds for disciplinary action under G.S. 90-113.44.

(3) The applicant is qualified for certification pursuant to the requirements of this Article and any rules adopted pursuant to it.

(4) The applicant has, at a minimum, a high school diploma or a high school equivalency certificate.

(5) The applicant has signed a form attesting to the intention to adhere fully to the ethical standards adopted by the Board.

(5a) The applicant submits a complete criminal history record check pursuant to G.S. 90-113.46A.

(6) The applicant has completed 270 hours of Board-approved education. The Board may prescribe that a certain number of hours be in a course of study for substance abuse counseling and that a certain number of hours be in a course of study for substance abuse prevention consulting. Independent study hours shall not compose more than fifty percent (50%) of the total number of hours required for initial credentialing.

(7) The applicant has documented completion of a minimum of 300 hours of Supervised Practical ~~Training and~~Training, has provided a Board-approved supervision contract between the applicant and an ~~approved supervisor.~~applicant supervisor, and has been deemed recommended by the applicant supervisor to advance in the credentialing process.

(8) The applicant for substance abuse counselor has completed ~~either~~ a total of 6,000 hours of supervised experience in the field, whether paid or ~~volunteer, or, if a graduate of a Board-approved master's degree program, a total of 3,000 hours of supervised experience in the field, whether paid or~~ volunteer. The applicant for substance abuse prevention consultant has completed a total of ~~10,000~~6,000 hours supervised experience in the field, whether paid or volunteer, or 4,000 hours if the applicant has at least a bachelors degree in a human services field from a regionally accredited college or university.

(9) The applicant has ~~successfully completed~~obtained a passing score on a written ~~examination and~~examination. An applicant for certification as a substance abuse counselor must also obtain a passing score on an oral examination promulgated and administered by the Board.

(b) The Board shall issue a certificate certifying an individual as a "Certified Clinical Supervisor" if, in addition to meeting the requirements of subdivisions (a)(1) through (5) of this section, the applicant:

(1) Submits proof of designation by the Board as a clinical supervisor intern.

(2) Prior to June 30, 1998, the applicant presents proof that the applicant has 12,000 hours experience in alcohol and drug abuse counseling and a bachelors degree or 8,000 hours experience in alcohol and drug abuse counseling and a minimum of a master's degree. After June 30, 1998, the applicant shall present proof that the applicant has a minimum of a master's degree in a human services field with a clinical application from a regionally accredited college or university.

(3) Has 6,000 hours experience as a substance abuse clinical supervisor if the applicant has a bachelors degree or 4,000 hours experience if the applicant has a master's degree in a human services field with a clinical application from a regionally accredited college or university.

(4) Has 30 hours of substance abuse clinical supervision specific education or training. These hours shall be reflective of the ~~12 core functions~~Twelve Core Functions in the applicant's clinical application and practice and may also be counted toward the applicant's ~~recertification~~ renewal as a substance abuse ~~counselor~~counselor or a clinical addictions specialist.

(5) Submits a letter of reference from a professional who can attest to the applicant's supervisory competence and two letters of reference from either counselors who have been supervised by the applicant or professionals who can attest to the applicant's competence.

(5a) Submits a complete criminal history record check pursuant to G.S. 90-113.46A.

(6) ~~Successfully completes~~Obtains a passing score on a written examination administered by the Board.

A person who practices as a certified clinical supervisor in addition to practicing as a certified substance abuse counselor shall be exempt from the practice supervision contract requirement.

(b1) The Board shall designate an applicant as a "Clinical Supervisor Intern" if, in addition to meeting the requirements of subdivisions (a)(1) through ~~(5)~~(5a) of this section, the applicant meets the following qualifications:

(1) Submits an application, resume, and official transcript showing that the applicant has obtained a master's degree in a human services field with a clinical application from a regionally accredited college or university.

(2) Submits verification statements.
(3) Submits proof of ~~certification~~ credentialing as a certified substance abuse ~~counselor or a certified~~counselor, a licensed clinical addictions ~~specialist.~~specialist, or certification or licensure through an organization granted deemed status by the Board.
(4) Submits documentation establishing that the applicant has completed at least fifty percent of the required clinical supervision specific training hours as defined by the Board.

(c) The Board shall issue a ~~certificate certifying~~license credentialing an applicant as a "~~Certified~~ Licensed Clinical Addictions Specialist" if, in addition to meeting the requirements of subdivisions (a)(1) through ~~(5)~~(5a) of this section, the applicant meets one of the following criteria:

(1) Criteria A. – The applicant:
a. Has a minimum of a master's degree with a clinical application in a human services field from a regionally accredited college or university.
b. Has two years postgraduate supervised substance abuse counseling experience.
c. Submits three letters of reference from ~~certified~~ licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.
d. Has achieved a combined score set by the Board on a master's level written and oral examination administered by the Board.
e. Has attained 180 hours of substance abuse specific training ~~as described~~from either a regionally accredited college or university, which may include unlimited independent study, or from training events of which no more than fifty percent (50%) shall be in independent study. All hours shall be credited according to the standards set forth in G.S. 90-113.41A.
f. The applicant has documented completion of a minimum of 300 hours of supervised practical training and has provided a Board-approved supervision contract between the applicant and an ~~approved~~ applicant supervisor.

(2) Criteria B. – The applicant:
a. Has a minimum of a master's degree with a clinical application in a human services field from a regionally accredited college or university.
b. Has been certified as a substance abuse counselor.
c. Has one year of postgraduate supervised substance abuse counseling experience.
d. Has achieved a passing score on a master's level written examination administered by the Board.

e. Submits three letters of reference from ~~certified~~ either licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

(3) Criteria C. – The applicant:

a. Has a minimum of a master's degree in a human services field with both a clinical application and a substance abuse specialty from a regionally accredited college or university that includes 180 hours of substance abuse specific education and training pursuant to G.S. 90-113.41A.

b. Has one year of postgraduate supervised substance abuse counseling experience.

c. Has achieved a passing score on an oral examination administered by the Board.

d. Submits three letters of reference from ~~certified~~ licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

(4) Criteria D. – The applicant has a substance abuse certification from a professional discipline that has been granted deemed status by the Board.

(d) The Board shall issue a certificate certifying an applicant as a "Substance Abuse ~~Certified~~ Residential Facility Director" ~~if, in addition to meeting the requirements of subdivisions (a)(1) through (5) of this section,~~ if the applicant:

(1) Has been ~~certified~~ credentialed as a substance abuse counselor or a clinical addictions specialist.

(2) Has 50 hours of Board approved academic or didactic management specific training or a combination thereof. Independent study may compose up to fifty percent (50%) of the total number of hours required for initial credentialing.

(3) Submits letters of reference from the applicant's current supervisor and a colleague or coworker.

(d1) The Board shall issue a certificate certifying an applicant as a 'Certified Criminal Justice Addictions Professional', with the acronym 'CCJP', if in addition to meeting the requirements of subdivisions (a)(1) through (5a) of this section, the applicant:

(1) Has attained 270 hours of Board-approved education or training, unless the applicant has attained a minimum of a masters degree with a clinical application and a substance abuse specialty from a regionally accredited college or university whereby the applicant must only obtain 180 hours. The hours of education shall be specifically related to the knowledge and skills necessary to perform the tasks within the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated, 'IC&RC/AODA, Inc.,' criminal justice addictions professional performance domains as they relate to both adults and juveniles. Independent study may compose up to fifty

percent (50%) of the total number of hours obtained for initial certification or renewal.

(2) Has documented 300 hours of Board-approved supervised practical training. This supervision shall mean the administrative, clinical, and evaluative process of monitoring, assessing, and enhancing professional performance. A minimum of 10 hours of supervision in each criminal justice domain established by the IC&RC/AODA, Inc., is required.

(3) Has provided documentation of supervised work experience providing direct service to clients or offenders involved in one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections. The applicant must meet one of the following criteria:

a. Criteria A. – In addition to having a high school degree or GED, the applicant has a minimum of 6,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services that have been obtained during the past 10 years.

b. Criteria B. – In addition to having an associate degree, the applicant has a minimum of 5,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services obtained during the past 10 years.

c. Criteria C. – In addition to having at least a bachelors degree, the applicant has a minimum of 4,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services and this experience has been obtained during the past 10 years.

d. Criteria D. – In addition to having at least a masters degree in a human services field, the applicant has a minimum of 2,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services that has been obtained during the past 10 years.

e. Criteria E. – In addition to having at least a masters degree in a human services field with a specialty from a regionally accredited college or university that includes 180 hours of substance abuse specific education or training, the applicant has a minimum of 2,000 hours of postgraduate supervised substance abuse counseling experience.

f. Criteria F. – In addition to having obtained the credential of a certified clinical addictions specialist or other advanced credential in a human services field from an organization that has obtained deemed status with the Board, the applicant has a minimum of 1,000 hours of documented work experience in

direct services in criminal justice or addictions services that has been obtained during the past 10 years.

(4) Has passed the IC&RC/AODA, Inc., certified criminal justice addictions professional written examination.

(e) The Board shall publish from time to time information in order to provide specifics for potential applicants of an acceptable educational curriculum and the terms of acceptable supervised fieldwork experience.

(f) ~~Effective until January 1, 2001, any person who is certified as a certified clinical supervisor or who functions by his or her job description as a certified clinical supervisor shall be qualified to supervise applicants for certified clinical supervisor.~~

~~Effective from January 1, 2001 until January 1, 2003, only a person who is certified both as a certified clinical supervisor and as a certified clinical addictions specialist shall be qualified to supervise applicants for certified clinical addictions specialist, but a person who is certified as a certified clinical supervisor or a certified clinical addictions specialist shall be qualified to supervise an applicant for certification as a certified substance abuse counselor.~~

Effective January 1, 2003, only a person who is certified as a certified clinical supervisor or a clinical supervisor intern shall be qualified to supervise applicants for certified clinical supervisor and certified substance abuse counselor and applicants for ~~certified~~ licensed clinical addictions specialist who meet the qualifications of their credential other than through deemed status as provided in G.S. 90-113.40(c)(4).

"§ 90-113.40A. Requirements for registration.

(a) Upon application and payment of the required fee, the Board shall issue a registration designating an applicant as a registrant if the applicant:

(1) Provides documentation that he or she has received a high school diploma, or the equivalent, and evidence of any baccalaureate or advanced degrees the applicant has received.

(2) Completes a registration application on a form provided by the Board.

(3) Provides documentation of three hours of educational training in ethics.

(4) Signs a form attesting to the applicant's commitment to adhere to the ethical standards adopted by the Board.

(4a) Provides a complete criminal history record check pursuant to G.S. 90-113.46A.

(5) Signs a supervision contract provided by the Board that documents the proposed supervision process by an ~~approved~~ applicant supervisor.

(b) Registrant status shall be maintained for a period of up to five years while the registrant is in the process of completing his or her requirements for ~~certification~~ credentials pursuant to this Article. If at the end of a five-year period a registrant has not obtained ~~certification~~ a credential under this Article, the Board shall renew the registration for up to an additional five-year period after the registrant pays the required fee and complies with all requirements for registration pursuant to G.S. 90-113.40A. The Board shall terminate the registration of any registrant who fails to renew his or her registration.

(c) The registrant shall notify the Board of any criminal conviction imposed during the period of registration.

"§ 90-113.40B. ~~Approved~~ Applicant supervision.

The Board shall designate a person as an ~~approved~~ applicant supervisor of individuals applying for ~~registration or certification~~registration, certification, or licensure as a substance abuse professional as follows:

(1) A certified clinical supervisor shall supervise a clinical supervisor intern.

(2) A certified clinical supervisor or a clinical supervisor intern shall supervise a substance abuse residential facility director applicant, a clinical addictions specialist applicant, or a substance abuse counselor applicant.

~~(3) A certified clinical supervisor, a clinical supervisor intern, a certified clinical addictions specialist, or a certified substance abuse counselor shall supervise a registrant who provides DWI assessments.~~

(4) A certified substance abuse prevention consultant with a minimum of three years of professional experience, a certified clinical supervisor, or a clinical supervisor intern shall supervise a registrant applying for certification as a prevention consultant.

(5) Pursuant to the deemed status procedure under G.S. 90-113.41A, the supervision requirements described in subdivisions (1) through (4) of this section shall not apply to persons applying for ~~certification~~ licensure as a ~~certified~~ licensed clinical addictions specialist.

(6) A criminal justice addictions professional applicant shall be supervised by a certified clinical supervisor or clinical supervisor intern.

"§ 90-113.41. Examination.

(a) Except for those individuals applying for ~~certification~~ licensure under G.S. 90-113.41A, applicants for certification or licensure under this Article shall file an application at least 60 days prior to the date of examination and upon the forms and in the manner prescribed by the Board. The application shall be accompanied by the appropriate fee. No portion of this fee is refundable. Applicants who fail an examination may apply for reexamination upon the payment of another examination fee.

(b) Each applicant for certification or licensure under this Article shall be ~~examined~~ tested in an examination ~~that is consistent with the examination requirements of~~developed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated and the standards adopted by professional disciplines granted deemed status or their successor organizations.

(c) Applicants for certification or licensure shall be examined at a time and place and under the supervision that the Board determines. Examinations shall be given in this State at least twice each year.

(d) Applicants may obtain their examination scores and may review their examination papers in accordance with rules the Board adopts and agreements between Board-authorized test development companies.

"§ 90-113.41A. Deemed status.

(a) To be granted deemed status by the Board, a credentialing body of a professional discipline or its designee shall demonstrate that its substance abuse ~~certification~~ credentialing program substantially meets the following:

(1) Each person to whom the credentialing body awards credentials following the effective date of this act meets and maintains minimum requirements in substance abuse specific content areas. Each person also has a minimum of a master's degree with a clinical application in a human services field.

(2) The body requires 180 hours, or the equivalent thereof, of substance abuse specific education and training that covers the following content areas:

a. Basic addiction and cross addiction Physiology and Pharmacology of Psychoactive drugs that are abused.

b. Screening, assessment, and intake of clients.

c. Individual, group, and family counseling.

d. Treatment, planning, reporting, and record keeping.

e. Crisis intervention.

f. Case management and treatment resources.

g. Ethics, legal issues, and confidentiality.

h. Psychological, emotional, personality, and developmental issues.

i. ~~Coexisting~~ Co-occurring physical and mental disabilities.

j. Special population issues, including age, gender, race, ethnicity, and health status.

k. Traditions and philosophies of recovery treatment models and support groups.

(3) The program requires one year or its equivalent of post-degree supervised clinical substance abuse practice. At least fifty percent (50%) of the practice shall consist of direct substance abuse clinical care.

(b) The professional discipline seeking deemed status shall require its members to adhere to a code of ethical conduct and shall enforce that code with disciplinary action.

(c) The Board may grant deemed status to any professional discipline that substantially meets the standards in this section. Once such status has been granted, an individual within the professional discipline may apply to the Board for ~~certification as a certified clinical addictions specialist.~~the credential of licensed clinical addictions specialist.

(d) The Standards ~~and Credentialing~~ Committee of the Board shall review the standards of each professional discipline every third year from the date it was granted deemed status to determine if the discipline continues to substantially meet the requirements of this section. If the Committee finds that a professional discipline no longer meets the requirements of this section, it shall report its findings to the Board at the Board's next regularly scheduled meeting. The deemed status standing of a

professional discipline's credential may be discontinued by a two-thirds vote of the Board.

"§ 90-113.41B. Change of name or address.

Every person licensed, ~~certified~~ certified, or registered under the provisions of this Article shall give written notice to the Board of any change in his or her name or address within 60 business days after the change takes place.

"§ 90-113.42. ~~Exemptions.~~Violations; exemptions.

(a) It shall be unlawful for any person not licensed or otherwise credentialed as a substance abuse professional pursuant to this Article to engage in those activities set forth in the scope of practice of a substance abuse professional under G.S. 90-113.31B, unless that person is regulated by another profession or is a registrant or intern as defined by this Article.

(b) It is not the intent of this Article to regulate members of other regulated professions who provide substance abuse services or consultation in the normal course of the practice of their profession. ~~Accordingly, this~~

(c) This Article does not apply to any person registered, certified, or licensed by the State or federal government to practice any other occupation or profession while rendering substance abuse services or consultation in the performance of the occupation or profession for which the person is registered, certified, or licensed.

(d) Only individuals ~~certified~~ registered, certified, or licensed under this Article may use the title ~~certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director.~~'Certified Substance Abuse Counselor', 'Certified Substance Abuse Prevention Consultant', 'Certified Clinical Supervisor', 'Licensed Clinical Addictions Specialist', 'Certified Substance Abuse Residential Facility Director', 'Certified Criminal Justice Addictions Professional', 'Substance Abuse Counselor Intern', 'Clinical Addictions Specialist Intern', 'Clinical Supervisor Intern', or 'Registrant'.

"§ 90-113.43. Illegal practice; misdemeanor penalty.

Except as otherwise authorized in this Article, no person shall:

(1) ~~Practice,~~Offer substance abuse professional services, practice, attempt to practice, or supervise while holding himself or herself out to be a certified ~~substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist, or certified residential facility director~~substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified or licensed clinical addictions specialist, clinical addictions specialist intern, substance abuse residential facility director, certified criminal justice addictions professional, clinical supervisor intern, substance abuse prevention consultant, or registrant without first having obtained a certificate of ~~certification~~ registration, certification, or licensure from the Board.

(2) Use in connection with any name any letters, words, numerical codes, or insignia indicating or implying that this person is a ~~certified~~

registrant, substance abuse counselor, ~~certified~~ substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ clinical addictions specialist, ~~or~~ certified substance abuse residential facility ~~director~~ director, substance abuse counselor intern, or clinical addictions specialist intern unless this person is ~~certified~~ registered, certified, or licensed pursuant to this Article.

(3) Practice or attempt to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ licensed clinical addictions specialist, certified criminal justice addictions professional, or certified substance abuse residential facility director with a revoked, lapsed, or suspended ~~certification.~~certification or license.

(4) Aid, abet, or assist any ~~uncertified~~ person to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ licensed clinical addictions specialist, ~~or~~ certified substance abuse residential facility ~~director~~ director, registrant, substance abuse counselor intern, clinical addictions specialist, or clinical supervisor intern in violation of this Article.

(5) Knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, ~~certified~~ licensed clinical addictions specialist, ~~or~~ certified substance abuse residential facility ~~director~~ director, substance abuse counselor intern, clinical addictions specialist intern, or clinical supervisor intern unless that person is ~~certified~~ registered, certified, or licensed under this Article.

(6) Repealed by S.L. 1997-492, s. 13.

(7) Practice, supervise, or attempt to practice or supervise or knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a designated substance abuse intern without being designated as such by the Board.

A person who engages in any of the illegal practices enumerated by this section is guilty of a Class 1 misdemeanor. Each act of unlawful practice constitutes a distinct and separate offense.

"**§ 90-113.44. Grounds for disciplinary action.**

(a) Grounds for disciplinary action for an applicant or credentialed professional include:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain ~~certification~~ licensure, certification, or registration or renewal of ~~certification~~ licensure, certification, or registration.

(2) The use of drugs or alcoholic beverages to the extent that professional competency is ~~affected, until proof of rehabilitation can be established.~~affected.

(2a) The use of drugs or alcoholic beverages to the extent that a substance abuse professional suffers impairment.

(3) Conviction of an offense under any municipal, State, or federal ~~narcotic or controlled substance law, until proof of rehabilitation can be established.~~law other than traffic laws as prescribed by Chapter 20 of the General Statutes.

(4) Conviction of a felony or other public offense involving moral ~~turpitude, until proof of rehabilitation can be established.~~turpitude. Conviction of a Class A-E felony shall result in an immediate suspension of ~~certification~~ licensure, certification, or registration for a minimum of one year.

(5) An adjudication of insanity or incompetency, until proof of recovery from this condition can be ~~established.~~established by a licensed psychologist or psychiatrist.

(6) Engaging in any act or practice in violation of any of the provisions of this Article or any of the rules adopted pursuant to it, or aiding, abetting, or assisting any other person in such a violation.

(7) The commission of an act of malpractice, gross negligence, or incompetence ~~in the practice of substance abuse counseling, substance abuse prevention consulting, clinical supervising, or in serving as a clinical addictions specialist, residential facility director, or a registrant.~~while serving as a substance abuse professional, intern, or registrant.

~~(8) Practicing as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, certified clinical addictions specialist or certified residential facility director without a valid certificate or practicing as a registrant without a valid registration.~~

(9) Engaging in conduct that could result in harm or injury to the public.

(10) Entering into a dual relationship that impairs professional judgment or increases the risk of exploitation with a client or supervisee.

(11) Practicing as a credentialed substance abuse professional outside of his or her scope of practice pursuant to G.S. 90-113.31B.

(b) Denial of an applicant's licensure, certification, or registration or the granting of licensure, certification, or registration on a probationary or other conditional status shall be subject to substantially the same rules and procedures prescribed by the Board for review and disciplinary actions against any person holding a license, certificate, or registration. A suspension of a credential resulting from impairment due to substance use, mental health, or medical disorder shall be imposed for at least six months beginning from the date of successful discharge from a residential substance abuse treatment program or other appropriate treatment modality determined as a result of an assessment by a Board-approved assessor. Disciplinary actions involving a clinical addictions specialist whose licensure is achieved through deemed status shall be initially heard by the specialist's credentialing body. The specialist may appeal the body's

decision to the Board. The Board shall, however, have the discretionary authority to hear the initial disciplinary action involving a credentialed professional.

"§ 90-113.45. Enjoining illegal practices.

(a) The Board may, if it finds that any person is violating any of the provisions of this Article or of the rules adopted pursuant to it, apply in its own name to the superior court for a temporary or permanent restraining order or injunction to restrain that person from continuing these illegal practices. The court may grant injunctive relief regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation. In the court's consideration of the issue of whether to grant or continue an injunction sought by the Board, a showing of conduct in violation of the terms of this Article shall be sufficient to meet any requirement of general North Carolina injunction law for irreparable damage.

(b) The venue for actions brought under this section is the superior court of any county in which the illegal acts are alleged to have been committed or in the county where the defendant resides.

"§ 90-113.46. Application of requirements of Article.

All persons ~~certified~~ credentialed by the North Carolina Substance Abuse Professional ~~Certification~~ Practice Board, Inc., as of July 1, 1994, shall be ~~certified~~ credentialed by the Board pursuant to this Article. All these persons are subject to all the other requirements of this Article and of the rules adopted pursuant to it.

"§ 90-113.46A. Criminal history record checks of applicants for registration, certification, or licensure.

(a) All applicants for registration, certification, or licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny registration, certification, or licensure to an applicant. The Board shall ensure that the State and national criminal history of an applicant is checked. The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, the fee required by the Department of Justice for providing this service, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) If an applicant's criminal history record check reveals one or more convictions as defined in G.S. 90-113.31A(14), the conviction shall not automatically bar issuance of a credential by the Board to the applicant. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.

(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(7) The subsequent commission by the person of a crime as defined in G.S. 90-113.31A(14).

If, after reviewing the factors, the Board determines that the grounds set forth in G.S. 90-113.44 exist, the Board may deny registration, certification, or licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(c) Limited Immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying registration, certification, or licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 2. Article 4 of Chapter 114 of the General Statutes is amended by adding the following new section to read:

"**§ 114-19.11A. Criminal record checks of applicants for registration, certification, or licensure as a substance abuse professional.**

The Department of Justice may provide to the North Carolina Substance Abuse Professional Practice Board from the State and National Repositories of Criminal Histories the criminal history of any applicant for registration, certification, or licensure pursuant to Article 5C of Chapter 90 of the General Statutes. Along with the request, the Board shall provide to the Department of Justice the fingerprints of the applicant, a form signed by the applicant consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 3. All members serving on the North Carolina Substance Abuse Professional Practice Board on the effective date of this act shall complete their current three-year terms. Upon completion of their terms, newly appointed or elected members of the Board shall serve four-year terms pursuant to G.S. 90-113.33, as enacted in Section 1 of this act.

SECTION 4. Notwithstanding G.S. 90-113.40(d1), as enacted by Section 1 of this act, the North Carolina Substance Abuse Professional Practice Board may certify a person as a certified criminal justice addictions professional during a limited period of 90 days from the date this act becomes effective and the credential is approved by the

IC&RC/AODA, Inc., if the applicant qualifies based on experience providing services to clients or offenders exhibiting substance abuse disorders and is working in a program determined by the Board to be integrally involved in at least one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections. In addition to meeting the requirements of G.S. 90-113.40(a)(1) through (5a), the person shall do the following:

(1) Provide two letters recommending certification from a current or former peer who functions in substantially the same professional capacity as determined by the Board.

(2) Provide one letter recommending certification from a person currently supervising or who has supervised the applicant within the previous five years attesting to the applicant's competency in the fields of substance abuse and criminal justice.

(3) Pay the criminal justice addictions professional certification fee for certification not to exceed one hundred fifty dollars ($150.00).

(4) Provide one of the following:

a. A high school diploma or a high school equivalency certificate, documentation of eight years or 16,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in at least one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

b. An associate degree and documentation of six years or 12,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

c. A bachelors degree in the human services field with four years or 8,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in at least one of the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

d. A masters degree or above in the human services field with two years or 4,000 hours of supervised work experience providing direct service to clients or offenders determined by the Board to be integrally involved in the three branches of the criminal justice system, which include law enforcement, the judiciary, and corrections.

(5) Provide documentation of at least 270 clock hours of board approved education and 300 hours of board approved supervised practical training, both in the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated., criminal justice addiction professional performance domains."

SECTION 5. This act is effective when it becomes law.

SENATE BILL 705:
Amend NC Substance Abuse Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 10, 2005
Introduced by:	Sen. Nesbitt	**Summary by:**	Ben Popkin
Version:	PCS to First Edition S705-CSSS		Committee Counsel

SUMMARY: ***Senate Bill 705 would provide for the licensure of substance abuse professionals; establish the credential of certified criminal justice addictions professional; require that applicants for registration, certification or licensure consent to a criminal history record check; and make a range of technical and conforming changes to the existing North Carolina Substance Abuse Professionals Certification Act. The bill would charge the North Carolina Substance Abuse Professional Certification Board with credentialing and licensing qualified substance abuse professionals rather than certifying them as is currently the case, and would change the Board's name to the North Carolina Substance Abuse Professional Practice Board to reflect its new role.***

CURRENT LAW: The North Carolina Substance Abuse Professional Certification Board administers a certification process for professionals engaged in the assessment, evaluation, and provision of counseling and therapeutic services to persons suffering from substance abuse or dependency. The Board is directed to ensure that Board authorized professional titles cannot be used by anyone unless they have actually obtained that title officially through the Board. Titles currently authorized by the Board include the following: certified clinical addictions specialist, certified clinical supervisor, certified residential facility director, certified substance abuse counselor, certified substance abuse prevention consultant and clinical supervisor intern.

The Board has the authority to investigate complaints about professionals who are either certified by the Board or in the process of becoming certified, but has no authority to investigate or pursue complaints about unregulated professionals.

BILL ANALYSIS: Senate Bill 705 would change the name of the certification authority for substance abuse professionals from the 'North Carolina Substance Abuse Professional Certification Board' to the 'North Carolina Substance Abuse Professional Practice Board' and expand its powers and duties to include licensure. Board membership would remain unchanged[1]; however, the term of membership would increase from three-year terms to four-year terms.

Senate Bill 705 would expand the Board's scope of authority to include practice protection, which would ensure that a person, unless otherwise exempted by statute, would be unable to practice as a substance abuse professional without successful completion of a mandatory licensing process through the Board. Those exempted by statute would include any person registered, certified, or licensed by the State or federal government to practice any other occupation or profession while rendering substance abuse

[1] Eleven credentialed professionals elected by the credentialed professionals, at least two of whom shall serve each of the four Division of Mental Health, Developmental Disabilities, and Substance Abuse Services regions of the State. Three laypersons or other professional disciplines who have shown a special interest in the field of substance abuse, nominated by the Nominating and Elections Committee, whose five members are elected by the Board. Two members from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services. Three public members, one appointed by each of the following people: the Governor, Speaker of the House of Representatives, and President Pro Tempore of the Senate.

services or consultation in the performance of the occupation or profession for which the person is registered, certified, or licensed[2].

The Board would offer a wide range of credentials to practitioners from entry level up to and including persons with a master's degree or higher (who would be eligible for licensure as clinical addictions specialists). The range of credentials would encompass persons who practice in substance abuse treatment, substance abuse prevention, substance abuse clinical supervision, substance abuse residential facility programs, and criminal justice settings. The bill would define substance abuse professional to include the following titles: a registrant, certified substance abuse counselor, substance abuse counselor intern, certified substance abuse prevention consultant, certified clinical supervisor, clinical addictions specialist intern, licensed clinical addictions specialist, certified substance abuse residential facility director, or certified criminal justice addictions professional. Each type of credential would carry its own educational, training, and experience requirements as determined by the Board. Credentials would require renewal every two years, conditioned upon meeting various levels of continuing education as determined by the type of credential being renewed.

The bill would set forth the scope of practice for each of the classifications of substance abuse professional[3] listed in the preceding paragraph, and make it unlawful for any person not licensed or otherwise credentialed as a substance abuse professional pursuant to Article 5C to engage in the activities included in the scope of practice given. Practicing outside of the scope of practice for which one is credentialed would subject a substance abuse professional to disciplinary action by the Board.

Any person currently certified to practice as a substance abuse professional would be considered to be credentialed and able to continue to practice in the field. Persons working the criminal justice area would be allowed to apply for status as a 'registrant' and given five years to complete the credentialing process to become a certified criminal justice addictions specialist. The bill would make it a Class 1 misdemeanor to offer or provide substance abuse counseling without being credentialed by the North Carolina Substance Abuse Professional Practice Board. The Board would establish and publish required standards to credential substance abuse professionals and would be able to use the credentialing standards of the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated and the standards adopted by professional disciplines granted deemed status or their successor organizations as guidelines.

EFFECTIVE DATE: The act would be effective when it becomes law.

BACKGROUND: Senate Bill 705 is the product of coordinated efforts over the past year and a half by the various parties involved in substance abuse services, including the state chapters of Psychology, Psychiatry and Social Work as well as the Division of MH/DD/SA, Division of Facility Services, the Division of Medical Services and the Division of Motor Vehicles. Other states have recognized the potential for harm to the public health, safety, or welfare, as there are currently at least 70 boards in the United States and other countries that offer competency-based certification, including all branches of the US Military and the federal Indian Health Services. New York is one of many states that have certification written into state administrative regulations. Eleven states have practice protection licensure of substance abuse professionals. The Legislative Committee on New Licensing Boards recommends the licensing of substance abuse professionals.

This summary was produced with the assistance of Cindy Avrette, Research Division Staff Attorney.

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[2] G.S. 90-113.42(c).
[3] G.S. 90-113.31A.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 960*

Short Title:	Study Child Nutrition Services Indir. Costs.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE TO STUDY THE IMPACT OF INDIRECT COSTS ASSOCIATED WITH THE INTEGRITY OF THE CHILD NUTRITION SERVICES PROGRAM IN THE PUBLIC SCHOOLS, AS RECOMMENDED BY THE STUDY COMMITTEE FOR CHILDHOOD OVERWEIGHT/OBESITY OF THE HEALTH AND WELLNESS TRUST FUND COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 960*
PROPOSED COMMITTEE SUBSTITUTE S960-PCS85235-LN-14

Short Title: Study Child Nutrition Services Indir. Costs. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE TO STUDY THE IMPACT OF INDIRECT COSTS ASSOCIATED WITH THE INTEGRITY OF THE CHILD NUTRITION SERVICES PROGRAM IN THE PUBLIC SCHOOLS, AS RECOMMENDED BY THE STUDY COMMITTEE FOR CHILDHOOD OVERWEIGHT/OBESITY OF THE HEALTH AND WELLNESS TRUST FUND.

The General Assembly of North Carolina enacts:

SECTION 1. The Joint Legislative Education Oversight Committee shall study and analyze the impact of indirect costs associated with the integrity of the Child Nutrition Services Program ("Program") in the public schools. In conducting the study, the Committee shall consider:

(1) The financial pressures on school cafeteria managers resulting from indirect costs being charged back to the Program; and

(2) How to reduce indirect costs that are charged back to the Program, thereby minimizing the financial incentive to sell high-fat, low-nutrient a la carte items.

The Committee shall report its findings and recommendations to the 2006 Regular Session of the 2005 General Assembly on or before May 1, 2006.

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

SENATE BILL 960:
Study Child Nutrition Services Indir. Costs

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 10, 2005
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition		Committee Staff
	S960-PCS85235-LN-14		

SUMMARY: ***Senate Bill 960 would direct the Joint Legislative Education Oversight Committee to study the impact of indirect costs associated with the Child Nutrition Services Program in the public schools, as recommended by the Health and Wellness Trust Fund's Study Committee for the Prevention and Treatment of Childhood Overweight/Obesity.***

CURRENT LAW: The Health and Wellness Trust Fund Commission is charged by G.S. 147-86.33(a)(7) with administering the provisions of Article 6C of Chapter 147 of the North Carolina General Statutes.[1] This includes addressing the health needs of vulnerable and underserved populations and developing a comprehensive, community-based plan with goals and objectives to improve health and wellness of the people of North Carolina.[2]

BILL ANALYSIS: Senate Bill 960 directs the Joint Legislative Education Oversight Committee to study and analyze the impact of indirect cost associated with the Child Nutrition Services Program. The bill directs the Committee to consider:

- Financial pressures on school cafeteria managers resulting from indirect costs being charged back to the Program; and
- How to reduce those costs, minimizing the financial incentive to sell high fat, low nutrient a la carte items.

The Committee will report its findings and recommendations to the 2006 Regular Session of the 2005 General Assembly on or before May 1, 2006.

EFFECTIVE DATE: The act is effective when it becomes law.

BACKGROUND: To address North Carolina's obesity epidemic among children and youth, the Health and Wellness Trust Fund has established a study committee known as Fit Families NC. This study committee is comprised of twenty (20) experts with diverse backgrounds from across the State. The mission of Fit Families NC is to raise awareness of the problem support activity friendly communities, promote more physical activity and better nutrition, and conduct research to determine which policies and programs are most effective in helping families and communities make healthier choices.[3] The proposed legislation is a recommendation of the Study Committee for the Prevention and Treatment of Childhood Overweight/Obesity.

S0960e1-SMSQ-PCS85235-LN-14

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[1] G.S. 147-86.33(a)(7)
[2] Source-http://www.hwtfc.org/pdffiles/FitFamilies-CommitteeCharter.pdf
[3] Source-http://www.hwtfc.org/htmfiles/fundprty_obesity-FitFamilies.html

VISITOR REGISTRATION

SENATE HEALTH CARE COMMITTEE MAY 11, 2005

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sally Cameron	NC Psychological Assoc
Jessica Sage	NC Family Policy Council
Lu Hodge	KCCH
M McBeason	Cystic Drug
Jennifer M. Bennett	East Carolina Univ. Brody School of Medicine student
Kristin Ratcliff, RN	Nurse of the Day WFUBMC Nurse Anesthesia Program
Janice Daugherty, RN	Doctoral Nurse Practitioner Brody School of Medicine at East Carolina
Suzanne Bradley	Governors Office
Stephanie Erb	SBE
Sharon Pearce	NC Assoc of Nurse Anesthetists
Roz Switt	NCCCP
Jennifer Sahm	NASW NC/CPANM

VISITOR REGISTRATION

SENATE HEALTH CARE COMMITTEE MAY 11, 2005

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann Christian	Atty
Mildred Spearman	NCDOC
Spencer Clark	DMHDDSAS
Helen Wolstenholme	NCSAPCB
Janice Peterson	Certification Board
John Cyrus	NCSG
John McHugh	GOVOFFICE
Susan Hansen	WCPSS
Lee-Ann Cox	NCPA
Amy Jo Horne	NCMS
Deanne Stevens	nursing
Katherine Joyce	NCASA
Molly Ryan	NCSBA
Jim Hall	NCSSB/RUCC
Joseph Jordan	NCSAPCB

VISITOR REGISTRATION

SENATE HEALTH CARE COMMITTEE MAY 11, 2005

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rebecca Troutman	NCAEC
HART GRIMES	NCSAPCB
[illegible]	NC Council
[illegible]	[illegible]
[illegible]	NCSA
Dana Simpson	Smith Anderson
Gene Causby	NCSFSA
Cindy S. Melton	NCSFSA
LYNN HOGGARD	NCDPI
Mike Arnold	HWTFC
Robin Huffman	NC Psychiatric Assoc
Myron Terry	Pfizer Inc

Senate Health Care Committee
Wednesday, May 18, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 35	ADET School/Fee/Qualis. Increase.	Representative Sauls Representative Alexander Representative Insko
SB 42	Home Care Changes.	Senator Swindell IV
SB 1074	Facility Quality and Safety Improvements.	Senator Rand
SB 1161	Central Registry/MH Beds/Invol. Comm.	Senator Apodaca

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 18, 2005

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

FAVORABLE

H.B.(CS #1) **35** ADET School/Fee/Qualis. Increase.
Sequential Referral: Finance
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 18, 2005

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

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

S.B. **1074** Facility Quality and Safety Improvements.

Draft Number:	35227
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, May 18, 2005
11:00 A.M.
Room 544, Legislative Office Building

Minutes

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 18, 2005 in Room 544 of the Legislative Office Building, with fifteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham introduced Representative Alexander to present House Bill 35, ***ADET School/Fee/Qualis. Increase***, which has a sequential referral to Finance. Representative Alexander stated the bill will increase the fee paid by participates to the alcoholic and drug education traffic schools, to increase the amount that is removed to the Department of Health and Human Services by the area Mental Health Services Facilities, to require minimum qualifications for the instructors at the ADET Schools, to increase the number of hours in ADET Schools, and to require the Department to establish an evaluation tool. This bill came from the Joint Oversight Committee on Mental Health Developmental Disabilities and Substance Abuse Services. Senator Dannley moved for a favorable report and stated the bill has a sequential referral to Finance. The bill passed and will be sent to Finance.

Senate Bill 42, ***Home Care Changes***, was scheduled to be heard but was removed from the calendar.

Senator Rand brought his bill, Senate Bill 1074, ***Facility Quality and Safety Improvements***, forward, with a proposed committee substitute, and a motion was made to adopt it. Senator Rand stated this is a part of his continuing interest in Group Homes. The bill requires County Adult Care Home Inspectors to attend DHHS training and increases the penalties for violations in the Mental Health Care Facilities. It requires DHHS inspectors to inspect Adult Care and Mental Health Facilities annually. It provides adequate staffing resources to meet the annual inspections as well as the regulation inspections. The bill requires providers to post the hotline; DHHS toll free line for clients and families to report violations. It gives the Secretary the authority to assume a county regulator's responsibilities if DHHS determines the counties are not doing what they should. It provides DHHS with the authority to review and revoke operator's licenses if the provider has not served any children in the prior year. It establishes penalties for providers who fail to report or who report false information in regard to ownership and financial interest. It prohibits home health agencies from employing people with criminal histories. The bill creates an easy accessible database to allow DHHS, locate government providers, as well as clients and families to get information about the tract records of these residential facilities. Senator Forrester asked about adult care homes by inquiring if they have ombudsman like the nursing homes. DHHS stated they do. Senator Forrester also asked if there are criteria for their administrators stating that nursing homes require their administrator to be certified. Bob Fitzgerald, Director of Division of Facility Services with DHHS, stated there are standards for both group home administrators and adult care administrators. They have

to be certified however they do not have to have college degrees. Senator Forrester had a follow up question asking if they can close down a facility if it is not in compliance. Mr. Fitzgerald answered they certainly can and that it is in the statutes. Senator Goodall asked if the county department of social services would have more burdens on them due to this legislation. Rob Lammè, with DHHS stated that the departments were consulted in the development of the bill. Sen. Goodall also asked if the Division of Facility Services Audits are announced or are they surprise audits. Mr. Bob Fitzgerald, with DHHS replied the audits are never announced. Senator Kinnaird asked if there is an oversight committee for adult care homes. The Department states there are oversight committees. Senate Kinnaird also asked if this bill addressed the issue of mental health patients being mixed in with the elderly. Mr. Fitzgerald stated there was nothing in this bill addressing this issue. Senator Forrester moved for a favorable report and also asked the minimum size of a facility to have a license. Mr. Fitzgerald stated the group home facilities licensed under mental health have a license capacity of 1-6 beds. They feel the small size is more appropriate. Lou Wilson, NC Association of Long Term Care Facilities expressed concerns about the doubling of fines and penalties. Senator Nesbitt stated his concerns about the fines and being afraid that people will be put out of business. Senator Rand pointed out the Penalties Review Committee meets semi-annually and is composed of a pharmacist, a nurse, a representative of the nursing home, a representative of the adult care home, and two public members. They hear from the providers and the residents. Senator Hartsell asked what is the impact of the recommendation from the Penalties Review Committee. Senator Rand stated that it is only a recommendation. Previously Senator Forrester made the motion, unfavorable as to bill, but favorable as to the committee substitute bill with a sequential referral to Appropriations/Base Budget, which passed unanimously.

Senate Bill 1161, ***Central Registry/MH Beds/Invol.Comm.***, will be heard next week.

The meeting adjourned at 11:55 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 35

Committee Substitute Favorable 4/12/05

Short Title: ADET School/Fee/Qualis. Increase. (Public)

Sponsors:

Referred to:

February 2, 2005

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR ATTENDING AN ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL, TO INCREASE THE AMOUNT REMITTED FROM THE FEE BY AN AREA FACILITY TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO PROVIDE ADET SCHOOL INSTRUCTION, TO DIRECT THE COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO MODIFY THE RULES REGARDING THE NUMBER OF INSTRUCTIONAL HOURS AND MAXIMUM ADET SCHOOL CLASS SIZE, AND TO REQUIRE THE DEPARTMENT TO ESTABLISH AN OUTCOMES EVALUATION STUDY ON THE EFFECTIVENESS OF SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY 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-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 one hundred dollars ($100). A person shall pay to a ~~treatment facility or~~ school a fee of ~~seventy-five dollars ($75.00).~~one hundred sixty dollars ($160.00). A person shall pay to a treatment facility 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~~A facility shall remit to the Department ~~five percent (5%)~~ ten percent (10%) 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 2. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(d1) Persons Authorized to Provide Instruction. – Beginning January 1, 2009, individuals who provide ADET school instruction as a Department-authorized ADETS instructor must have at least one of the following qualifications:

(1) Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.

(3) Certified Substance Abuse Prevention Consultant (CSAPC), as defined by the Commission."

SECTION 3. The Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall revise its rules regarding the number of instructional program hours and the class size for ADET schools. The minimum program hours of instruction shall not be less than 16 hours. The maximum class size shall not be more than 20 participants.

SECTION 4. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(j) The Department shall establish an outcomes evaluation study on the effectiveness of substance abuse services provided to persons who obtain a certificate of completion under G.S. 20-17.6 as a condition for restoration of a drivers license. The findings of the study shall be reported every two years to the Joint Legislative Commission on Governmental Operations. The Department shall submit an initial report on the findings of the study to the Commission no later than December 31, 2007, and shall submit a report to the Commission every two years following that date."

SECTION 5. Section 1 becomes effective when the rules adopted under Section 3 of this act become effective and shall apply to fees charged for ADET school instruction that commences on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 35:
ADET School/Qualis. Increase.

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 18, 2005
Introduced by:	Rep. Alexander	**Summary by:**	Shawn Parker
Version:	Second Edition		Committee Staff

SUMMARY: ***The bill would increase the fee paid by participants to schools providing an alcohol and drug education traffic (ADET) school; increase the amount remitted to the Department of Health and Human Services by area mental health facilities; require minimum qualifications for instructors for the ADET schools; increase the number of hours of ADET school; and require the Department to establish an evaluation tool for the ADET school.***

CURRENT LAW: Persons convicted of DWI, commercial vehicle DWI, or driving while less than 21 years old after consuming alcohol must receive a "certificate of completion" in order to have their drivers license restored. The ADET school is a requirement for that certificate completion if the required substance abuse assessment does not identify a substance abuse handicap, the person has no previous DWI offense conviction, the person had an alcohol concentration of .14 or less, the person did not refuse to submit to a chemical test, and the person meets the admission criteria for Level .5 (Early Intervention).
The fee for ADET is $100 for the assessment, and a fee $75 to the treatment facility or school.

BILL ANALYSIS:

Section 1. The bill would increase the fee paid to schools from $75 to $160, and maintain the fee paid to treatment facilities at $75. The bill would also increase the amount remitted to the Department of Health and Human Services from the fees collected by facilities from 5% to 10%. **Effective when the Commission revises it's rules as required under Section 3 of the bill.**

Section 2. Beginning **January 1, 2009**, the bill would require persons providing instruction at ADET school to have at least one of the following qualifications:

1. Certified Substance Abuse Counselor (CSAC), as defined by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services ("Commission").
2. Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.
3. Certified Substance Abuse Prevention Consultant (CSAPC), as defined by the Commission."

Section 3. The bill would direct the Commission to revise its rules regarding ADET school to increase the number of hours to at least 16 hours and reduce class size to no more than 20 participants.

Section 4. The bill would required the Department of Health and Human Services to establish an outcomes evaluation study on the effectiveness of substance abuse services provided persons obtaining services as a condition of restoring their drivers license. The study shall be reported to Gov Ops every two years beginning on or before December 31, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 42*

Short Title:	Home Care Changes.	(Public)
Sponsors:	Senators Swindell, Dannelly, Allran; Boseman, Dalton, Purcell, Rand, Thomas, and Tillman.	
Referred to:	Health Care.	

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AND TO APPROPRIATE FUNDS TO INCREASE THE SURVEY CYCLE FOR LICENSED IN-HOME AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission ~~is authorized to~~ may adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules defining geographic service areas and staffing qualifications for licensed home care agencies.

(a3) The Commission shall adopt rules prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(a4) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. G.S. 131E-136 reads as rewritten:

"**§ 131E-136. Definitions.**

As used in this Part, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(1a) "Geographic service area" means the geographic area in which a licensed agency provides home care services.

(2) "Home care agency" means a private or public organization that provides home care services.

(2a) "Home care agency director" means the person having administrative responsibility for the operation of the agency.

(2b) "Home care client" means an individual who receives home care services.

(3) "Home care services" means any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:

a. Nursing care provided by or under the supervision of a registered nurse;

b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home;

c. Medical social services;

d. In-home aide services that involve hands-on care to an individual;

e. Infusion nursing services; and

f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.

The term does not include: health promotion, preventative health and community health services provided by public health departments; maternal and child health services provided by public health departments, by employees of the Department of Health and Human Services under G.S. 130A-124, or by developmental evaluation centers under contract with the Department of Health and Human Services to provide services under G.S. 130A-124; hospitals licensed under Article 5 of Chapter 131E of the General Statutes when providing follow-up care initiated to patients within six months after their discharge from the hospital; facilities and programs operated under the authority of G.S. 122C and providing services within the scope of G.S. 122C; schools, when providing services pursuant to Article 9 of Chapter 115C; the practice of midwifery by a person licensed under Article 10A of Chapter 90 of the General Statutes; hospices licensed under Article 10 of Chapter 131E of the General Statutes when providing care to a hospice patient; an individual who engages solely

in providing his own services to other individuals; incidental health care provided by an employee of a physician licensed to practice medicine in North Carolina in the normal course of the physician's practice; or nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (i) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided.

(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E."

SECTION 3. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§ 131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§ 131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part.

"**§ 131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.

(11) To be informed of supervisory accessibility and availability.

(12) To be advised of the agency's procedures for discharge.

(13) To receive a reasonable response to his or her requests of the agency.

(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"**§ 131E-144.4. Notice to client.**

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

(1) A copy of the declaration of home care clients' rights.

(2) The address and telephone number for information, questions, or complaints about services provided by the agency.

(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"**§ 131E-144.5. Implementation.**

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"**§ 131E-144.6. Enforcement and investigation.**

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint.

"**§ 131E-144.7. Confidentiality.**

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of five hundred fifty thousand dollars ($550,000) for the 2005-2006 fiscal year and the sum of five hundred fifty thousand dollars ($550,000) for the 2006-2007 fiscal year to increase the survey cycle to every two years for licensed only home care agencies.

SECTION 5. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 6. Section 4 of this act becomes effective July 1, 2005. Section 3 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1074

Short Title:	Facility Quality and Safety Improvements.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE STATUTORY CHANGES TO IMPROVE QUALITY AND SAFETY IN HOME CARE SERVICES, MENTAL HEALTH FACILITIES, ADULT CARE HOMES, AND CERTAIN HOSPITAL FACILITIES, AND TO APPROPRIATE FUNDS TO IMPLEMENT THE CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this Part. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care ~~service.~~service including defining the geographic service area in which a home care agency is licensed to operate.

(a2) The Commission shall adopt rules to establish staff qualifications including professional requirements for home care agency staff. The rules may require that one or more staff of an agency be either licensed or certified. The rules may establish minimum training and education qualifications for staff and may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the North Carolina General Statutes provided that the professional board evaluates applicants on a basis that protects the public health, safety, or welfare.

(a3) The Commission shall adopt rules for prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care ~~agencies.~~agencies and shall conduct an inspection of each agency at least every three years."

SECTION 1.(b) G.S. 131E-141 reads as rewritten:

"**§ 131E-141. Inspection.**

(a) The Department shall inspect home care agencies in accordance with rules adopted by the Commission to determine compliance with the provisions of this Part and the rules established by the Commission.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department who make these inspections may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been clients of the agency being inspected unless that client objects in writing to review of that client's records. Physicians, psychiatrists, nurses, and anyone else involved in giving treatment at or through an agency who may be interviewed by representatives of the Department may disclose to these representatives information related to any inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communication between physician and patient," or any other rule of law; provided the client has not made written objection to this disclosure. The agency, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews, except as noted in G.S. 131E-124(c), shall be kept confidential by the Department and not disclosed without written authorization of the client or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning an agency without the consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "`Public records' defined." Prior to releasing any information or allowing any inspections referred to in this section, the client must be advised in writing by the licensed agency that the client has the right to object in writing to release of information or review of the client's records and that by an objection in writing the client may prohibit the inspection or release of the records.

(c) An agency must provide each client with a written notice of the Division of Facility Services hotline number in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services."

SECTION 2.(a) G.S. 122C-23(e) reads as rewritten:

"(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.~~Initial licenses issued under the authority of this section shall be valid for not more than 15 months. Licenses

shall be renewed annually thereafter and shall expire at the end of the calendar year. 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. Licenses for facilities that have not served any clients during the previous 12 months are not eligible for renewal.

The Secretary may issue a provisional license for a period up to six months to a person obtaining the initial license for a facility. The licensee must demonstrate substantial compliance prior to being issued a full license.

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.~~when the noncompliance does not present an immediate threat to the health and safety of the individuals in the licensable facility. 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."

SECTION 2.(b) G.S. 122C-24.1(a) reads as rewritten:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violations Classified. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than ~~two hundred fifty dollars ($250.00)~~ five hundred dollars ($500.00) nor more than ~~five thousand dollars ($5,000)~~ ten thousand dollars

($10,000) for each Type A Violation in facilities or programs that serve ~~nine~~ six or fewer persons. The Department shall impose a civil penalty in an amount not less than ~~five hundred dollars ($500.00)~~ one thousand dollars ($1,000) nor more than ~~ten thousand dollars ($10,000)~~ twenty thousand dollars ($20,000) for each Type A Violation in facilities or programs that serve ~~10~~ seven or more persons.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation."

SECTION 2.(c) G.S. 122C-24.1(b) reads as rewritten:

"(b) Penalties for Failure to Correct Violations Within Time Specified. –

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to ~~two hundred dollars ($200.00)~~four hundred dollars ($400.00) for each day that the deficiency continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) of this section when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which it received a citation during the previous 12 months."

SECTION 2.(d) Effective July 1, 2007, G.S. 122C-25(a) reads as rewritten:

"**§ 122C-25. Inspections; confidentiality.**

(a) The Secretary shall make or cause to be made inspections that the Secretary considers necessary. Facilities licensed under this Article shall be subject to inspection

at all times by the Secretary. All residential facilities as defined in G.S. 122C-3(14)e. shall be inspected on an annual basis.

..."

SECTION 2.(e) G.S. 122C-25 is amended by adding the following new subsection to read:

"**§ 122C-25. Inspections; confidentiality.**

...

(d) All residential facilities, as defined in G.S. 122C-3(14)e. shall ensure that the Division of Facility Services complaint hotline number is posted conspicuously in a public place in the facility."

SECTION 3.(a) G.S. 131D-2(b)(1) reads as rewritten:

"(b) Licensure; inspections. –

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the 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. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted pursuant thereto, the Department shall issue a license for the balance of the calendar year. Licenses ~~issued~~ renewed under the authority of this section shall be valid for one year from the date of ~~issuance~~ renewal 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. The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of one hundred twenty-five dollars ($125.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of one hundred seventy-five dollars ($175.00) plus a nonrefundable annual per-bed fee of six dollars and twenty-five cents ($6.25). A license shall not be renewed if outstanding fees, 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."

SECTION 3.(b) G.S. 131D-2(b)(1a) reads as rewritten:

"(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this ~~subsection,~~subsection:

a. ~~the~~ The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. The Division of Facility Services shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter.

b. ~~In carrying out this requirement, the~~ The Department shall work with county departments of social services to do the routine monitoring in accordance with policy and procedures established by the Division of Facility Services and to have the Division of Facility Services oversee this monitoring and perform any required follow-up ~~inspection called for.~~inspection. The county department of social services shall document in a written report all onsite visits including monitoring visits, revisits, and complaint investigations. The county department of social services shall submit to the Division of Facility Services written reports of each facility visit within 15 working days of the visit.

c. The Division of Facility Services shall conduct and document annual and quarterly reviews of the county department of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

1. Sending staff of the Department to the county department of social services to provide technical assistance and to monitor the services being provided by the facility.
2. Advising county personnel as to appropriate policies and procedures.
3. Establishing a plan of action to correct county performance.

If within one year of completion of the intervention activities, the Secretary finds that the county department of social services is not providing the necessary monitoring services or fails to demonstrate reasonable efforts to do so, the Secretary may provide written notification of the failure to correct to the chair of the board of county commissioners and the chair of the county board of social services. The Secretary may determine

that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

d. The county department of social services' adult home specialists and their supervisors shall complete:

1. Eight hours of pre-basic training within 30 days of employment;
2. Thirty-two hours of basic training within three months of employment;
3. Twenty-four hours of post basic training within 90 days of the basic training program;
4. A minimum of eight hours of complaint investigation training within three months of employment; and
5. A minimum of 16 hours of statewide training annually by the Division of Facility Services.

Adult home specialists and their supervisors employed prior to and on the effective date of this sub-subparagraph must complete the required training components within six months of the effective date. If the required training is not completed within six months of the established time frames, the Secretary may provide written notification of the county's failure to train staff to the chair of the county board of commissioners and the chair of the county board of social services.

e. 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.

f. 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."

SECTION 3.(c) G.S. 131D-2 is amended by adding the following new subsection to read:

"(j) Adult care homes shall post the Division of Facility Services' complaint hotline number conspicuously in a public place in the facility."

SECTION 3.(d) G.S. 131D-34 reads as rewritten:

"**§ 131D-34. Penalties; remedies.**

(a) Violations Classified. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility which is found to be in violation of requirements of G.S. 131D-21 or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than ~~two hundred fifty dollars ($250.00)~~five hundred dollars ($500.00) nor more than ~~five thousand dollars ($5000)~~ ten thousand dollars ($10,000) for each Type A Violation in homes licensed for ~~nine~~ six or fewer beds. The Department shall impose a civil penalty in an amount not less than ~~five hundred dollars ($500.00)~~ one thousand dollars ($1,000) nor more than ~~ten thousand dollars ($10,000)~~twenty thousand dollars ($20,000) for each Type A Violation in facilities licensed for ~~10~~ seven or more beds.

(2) "Type B Violation" means a violation by a facility of the regulations, standards and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

(b) Penalties for failure to correct violations within time specified.

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to ~~two hundred dollars ($200.00)~~four hundred dollars ($400.00) for each day that the deficiency continues beyond the date specified for correction without just reason for such failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which it received a citation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a court-appointed temporary manager pursuant to Article 4 of this Chapter.

(c) Factors to be considered in determining amount of initial penalty. In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a resident has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1a) The gravity of the violation, including the probability that death or serious physical harm to a resident will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1b) The gravity of the violation, including the probability that death or serious physical harm to a resident may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131E-265 and other applicable State and federal laws and regulations;

(2a) Efforts by the licensee to correct violations;

(3) The number and type of previous violations committed by the licensee within the past 36 months;

(4) The amount of assessment necessary to insure immediate and continued compliance; and

(5) The number of patients put at risk by the violation.

(c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Secretary shall document the

findings in written record and shall make the written record available to all affected parties including:

~~(1) The penalty review committee;~~

(2) The local department of social services who is responsible for oversight of the facility involved;

(3) The licensee involved;

(4) The residents affected; and

(5) The family members or guardians of the residents affected.

(c2) Local county departments of social services and Division of Facilities Services personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation.

(d) The Department shall impose a civil penalty on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits material information on an application. The amount of the penalty shall be as is prescribed for a Type A Violation.

(e) Any facility wishing to contest a penalty 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 a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(f) Notwithstanding the notice requirements of G.S. 131D-26(b), any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began.

(g) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(g1) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:

(1) The cost of training does not exceed one thousand dollars ($1,000);

(2) The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and

(3) The training is:

a. Specific to the violation;

b. Approved by the Department of Health and Human Services; and

c. Taught by someone approved by the Department and other than the provider.

~~(h) The Secretary shall establish a penalty review committee within the Department, which shall review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129 as follows:~~

~~(1) The Secretary shall:~~

~~a. Administer the work of the committee;~~

~~b. Ensure provision of departmental staff review;~~

~~c. Evaluate the local departments of social services and the Division of Facility Services' penalty recommendations;~~

~~d. Ensure that recommendations by the Department are complete and submitted within 60 days of receipt of the initial recommendations from the local departments of social services or the Division of Facility Services; and~~

~~e. Provide written copies of all procedures to:~~

~~1. The penalty review committee;~~

~~2. The local department of social services who is responsible for oversight of the facility involved;~~

~~3. The licensee involved;~~

~~4. The residents affected; and~~

~~5. The families or guardians of the residents affected.~~

~~(2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:~~

~~a. A licensed pharmacist;~~

~~b. A registered nurse experienced in long-term care;~~

~~c. A representative of a nursing home;~~

~~d. A representative of an adult care home; and~~

~~e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long-Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long-Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this~~

~~subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.~~

~~(3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be employed by or own any interest in a nursing home or adult care home.~~

~~(4) Prior to serving on the committee, each member shall complete a training program provided by the Department of Health and Human Services that covers standards of care and applicable State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.~~

~~(5) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.~~

(i) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 4.(a) There is appropriated from the General Fund to the Department of Health and Human Services the sum of eight hundred thousand dollars ($800,000) for the 2005-2006 fiscal year. These funds shall be used for a provider tracking base system to include all facilities that are regulated by the Department. These funds shall be held in reserve subject to Office of State Budget and Management approval and the Office of Information Technology Services approval in accordance with the applicable provisions of S.L. 2004-129.

SECTION 4.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of seven hundred twenty-eight thousand five hundred twenty-one dollars ($728,521) for the 2005-2006 fiscal year and the sum of one million five hundred seventy-two thousand seven hundred twenty-four dollars ($1,572,724) for the 2006-2007 fiscal year. These funds shall be used to enable the Division of Facility Services to meet expanding demands of inspecting 24-hour residential facilities for the mentally ill, developmentally disabled, and substance abuse populations.

SECTION 4.(c) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of eight hundred twenty thousand two hundred fifty-one dollars ($820,251) for the 2005-2006 fiscal year and the sum of two million one hundred five thousand nine hundred fifty-five dollars ($2,105,955) for the 2006-2007 fiscal year. These funds shall be used to increase the capacity to license and inspect family care and adult care homes.

SECTION 4.(d) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of two hundred seventeen thousand three hundred eighty-two dollars ($217,382) for the 2005-2006 fiscal year and the sum of two hundred seventy-three thousand eight hundred forty-three dollars ($273,843) for the 2006-2007 fiscal year. These funds shall be used

to support additional FTE to facilitate more timely responses to complaints from providers, citizens, and consumers, and to increase timelines of reporting.

SECTION 4.(e) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of two hundred seventy-one thousand five hundred six dollars ($271,506) for the 2005-2006 fiscal year and the sum of three hundred forty-nine thousand five hundred ninety-one dollars ($349,591) for the 2006-2007 fiscal year. These funds shall be used to support additional FTE for the inspection of every non-Medicare certified home care agency to be inspected at least every 36 months.

SECTION 5. Section 4 of this act becomes effective July 1, 2005. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1074
PROPOSED COMMITTEE SUBSTITUTE S1074-CSRD-20 [v.4]

5/18/2005 10:26:16 AM

Short Title: Facility Quality and Safety Improvements. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE STATUTORY CHANGES TO IMPROVE QUALITY AND SAFETY IN HOME CARE SERVICES, MENTAL HEALTH FACILITIES, ADULT CARE HOMES, AND CERTAIN HOSPITAL FACILITIES, AND TO APPROPRIATE FUNDS TO IMPLEMENT THE CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this Part. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care ~~service.~~service including defining the geographic service area in which a home care agency is licensed to operate.

(a2) The Commission shall adopt rules to establish staff qualifications including professional requirements for home care agency staff. The rules may require that one or more staff of an agency be either licensed or certified. The rules may establish minimum training and education qualifications for staff and may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the North Carolina General Statutes provided that the professional board evaluates applicants on a basis that protects the public health, safety, or welfare.

(a3) The Commission shall adopt rules for prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care ~~agencies.~~agencies and shall conduct an inspection of each agency at least every three years."

SECTION 1.(b) G.S. 131E-141 reads as rewritten:

"**§ 131E-141. Inspection.**

(a) The Department shall inspect home care agencies in accordance with rules adopted by the Commission to determine compliance with the provisions of this Part and the rules established by the Commission.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department who make these inspections may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been clients of the agency being inspected unless that client objects in writing to review of that client's records. Physicians, psychiatrists, nurses, and anyone else involved in giving treatment at or through an agency who may be interviewed by representatives of the Department may disclose to these representatives information related to any inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communication between physician and patient," or any other rule of law; provided the client has not made written objection to this disclosure. The agency, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews, except as noted in G.S. 131E-124(c), shall be kept confidential by the Department and not disclosed without written authorization of the client or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning an agency without the consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "`Public records' defined." Prior to releasing any information or allowing any inspections referred to in this section, the client must be advised in writing by the licensed agency that the client has the right to object in writing to release of information or review of the client's records and that by an objection in writing the client may prohibit the inspection or release of the records.

(c) An agency must provide each client with a written notice of the Division of Facility Services hotline number in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services."

SECTION 2.(a) G.S. 122C-23(e) reads as rewritten:

"(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.~~Initial licenses issued under the authority of this section shall be valid for not more than 15 months. Licenses

shall be renewed annually thereafter and shall expire at the end of the calendar year. 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. Licenses for facilities that have not served any clients during the previous 12 months are not eligible for renewal.

The Secretary may issue a provisional license for a period up to six months to a person obtaining the initial license for a facility. The licensee must demonstrate substantial compliance prior to being issued a full license.

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.~~when the noncompliance does not present an immediate threat to the health and safety of the individuals in the licensable facility. 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."

SECTION 2.(b) G.S. 122C-24.1(a) reads as rewritten:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violations Classified. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than ~~two hundred fifty dollars ($250.00)~~ five hundred dollars ($500.00) nor more than ~~five thousand dollars ($5,000)~~ ten thousand dollars

($10,000) for each Type A Violation in facilities or programs that serve ~~nine~~ six or fewer persons. The Department shall impose a civil penalty in an amount not less than ~~five hundred dollars ($500.00)~~ one thousand dollars ($1,000) nor more than ~~ten thousand dollars ($10,000)~~ twenty thousand dollars ($20,000) for each Type A Violation in facilities or programs that serve ~~10~~ seven or more persons.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation."

SECTION 2.(c) G.S. 122C-24.1(b) reads as rewritten:

"(b) Penalties for Failure to Correct Violations Within Time Specified. –

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to ~~two hundred dollars ($200.00)~~four hundred dollars ($400.00) for each day that the deficiency continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) of this section when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which it received a citation during the previous 12 months."

SECTION 2.(d) Effective July 1, 2007, G.S. 122C-25(a) reads as rewritten:

"**§ 122C-25. Inspections; confidentiality.**

(a) The Secretary shall make or cause to be made inspections that the Secretary considers necessary. Facilities licensed under this Article shall be subject to inspection

at all times by the Secretary. All residential facilities as defined in G.S. 122C-3(14)e. shall be inspected on an annual basis.

..."

SECTION 2.(e) G.S. 122C-25 is amended by adding the following new subsection to read:

"**§ 122C-25. Inspections; confidentiality.**

...

(d) All residential facilities, as defined in G.S. 122C-3(14)e. shall ensure that the Division of Facility Services complaint hotline number is posted conspicuously in a public place in the facility."

SECTION 3.(a) G.S. 131D-2(b)(1) reads as rewritten:

"(b) Licensure; inspections. –

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the 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. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted pursuant thereto, the Department shall issue a license for the balance of the calendar year. Licenses ~~issued~~ renewed under the authority of this section shall be valid for one year from the date of ~~issuance~~ renewal 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. The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of one hundred twenty-five dollars ($125.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of one hundred seventy-five dollars ($175.00) plus a nonrefundable annual per-bed fee of six dollars and twenty-five cents ($6.25). A license shall not be renewed if outstanding fees, 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."

SECTION 3.(b) G.S. 131D-2(b)(1a) reads as rewritten:

"(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this ~~subsection,~~subsection:

a. ~~the~~ The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. The Division of Facility Services shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter.

b. ~~In carrying out this requirement, the~~ The Department shall work with county departments of social services to do the routine monitoring in Adult Care Homes in accordance with policy and procedures established by the Division of Facility Services and to have the Division of Facility Services oversee this monitoring and perform any required follow-up ~~inspection called for.~~inspection. The county department of social services shall document in a written report all onsite visits including monitoring visits, revisits, and complaint investigations. The county department of social services shall submit to the Division of Facility Services written reports of each facility visit within 20 working days of the visit.

c. The Division of Facility Services shall conduct and document annual reviews of the county department of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

1. Sending staff of the Department to the county department of social services to provide technical assistance and to monitor the services being provided by the facility.
2. Advising county personnel as to appropriate policies and procedures.
3. Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

d. The county department of social services' adult home specialists and their supervisors shall complete:

1. Eight hours of pre-basic training within sixty days of employment;

2. Thirty-two hours of basic training within six months of employment;
3. Twenty-four hours of post-basic training within six months of the basic training program;
4. A minimum of eight hours of complaint investigation training within six months of employment; and
5. A minimum of 16 hours of statewide training annually by the Division of Facility Services.

e. 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.

f. 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."

SECTION 3.(c) G.S. 131D-2 is amended by adding the following new subsection to read:

"(j) Adult care homes shall post the Division of Facility Services' complaint hotline number conspicuously in a public place in the facility."

SECTION 3.(d) G.S. 131D-34 reads as rewritten:

"**§ 131D-34. Penalties; remedies.**

(a) Violations Classified. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility which is found to be in violation of requirements of G.S. 131D-21 or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than ~~two hundred fifty dollars ($250.00)~~five hundred dollars ($500.00) nor more than ~~five thousand dollars ($5000)~~ ten thousand dollars ($10,000) for each Type A Violation in homes licensed for ~~nine~~ six or fewer beds. The Department shall impose a civil penalty in an amount not less than ~~five hundred dollars ($500.00)~~ one thousand dollars ($1,000) nor more than ~~ten thousand dollars ($10,000)~~twenty thousand dollars ($20,000) for each Type A Violation in facilities licensed for ~~10~~ seven or more beds.

(2) "Type B Violation" means a violation by a facility of the regulations, standards and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

(b) Penalties for failure to correct violations within time specified.

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to ~~two hundred dollars ($200.00)~~four hundred dollars ($400.00) for each day that the deficiency continues beyond the date specified for correction without just reason for such failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which it received a citation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a

court-appointed temporary manager pursuant to Article 4 of this Chapter.

(c) Factors to be considered in determining amount of initial penalty. In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a resident has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1a) The gravity of the violation, including the probability that death or serious physical harm to a resident will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1b) The gravity of the violation, including the probability that death or serious physical harm to a resident may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131E-265 and other applicable State and federal laws and regulations;

(2a) Efforts by the licensee to correct violations;

(3) The number and type of previous violations committed by the licensee within the past 36 months;

(4) The amount of assessment necessary to insure immediate and continued compliance; and

(5) The number of patients put at risk by the violation.

(c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Secretary shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The penalty review committee;

(2) The local department of social services who is responsible for oversight of the facility involved;

(3) The licensee involved;

(4) The residents affected; and

(5) The family members or guardians of the residents affected.

(c2) Local county departments of social services and Division of Facilities Services personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation.

(d) The Department shall impose a civil penalty on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits material information on the portion of the

licensure application requesting information on owners, administrators, principals or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A Violation.

(e) Any facility wishing to contest a penalty 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 a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(f) Notwithstanding the notice requirements of G.S. 131D-26(b), any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began.

(g) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(g1) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:

(1) The cost of training does not exceed one thousand dollars ($1,000);

(2) The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and

(3) The training is:

a. Specific to the violation;

b. Approved by the Department of Health and Human Services; and

c. Taught by someone approved by the Department and other than the provider.

(h) The Secretary shall establish a penalty review committee within the Department, which shall meet at least semi-annually to review violations and penalties imposed by the Adult Care Licensure Section; provide a forum for residents, guardians or families of residents, local department of social services and providers; and make recommendations to the Department for changes in policy, training or rules as a result

of its review and publish a report.~~review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129 as follows:~~

(1) The Secretary ~~shall:~~ shall administer the work of the Committee and provide notice of its meetings to the following parties involved in the penalties the Committee will be reviewing:

a. The licensed provider; ~~Administer the work of the committee;~~

b. The local department of social services that is responsible for oversight of the facility involved; ~~Ensure provision of departmental staff review;~~

c. The residents affected; and ~~Evaluate the local departments of social services and the Division of Facility Services' penalty recommendations;~~

d. The families or guardians of the residents affected. ~~Ensure that recommendations by the Department are complete and submitted within 60 days of receipt of the initial recommendations from the local departments of social services or the Division of Facility Services; and~~

~~e. Provide written copies of all procedures to:~~

~~1. The penalty review committee;~~

~~2. The local department of social services who is responsible for oversight of the facility involved;~~

~~3. The licensee involved;~~

~~4. The residents affected; and~~

~~5. The families or guardians of the residents affected.~~

(2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:

a. A licensed pharmacist;

b. A registered nurse experienced in long term care;

c. A representative of a nursing home;

d. A representative of an adult care home; and

e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.

(3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be employed by or own any interest in a nursing home or adult care home.

~~(4) Prior to serving on the committee, each member shall complete a training program provided by the Department of Health and Human Services that covers standards of care and applicable State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.~~

~~(5)~~(4) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.

(5) The Committee shall be co-chaired by:

(a) One member of the Department outside of the Division of Facility Services; and

(b) One member who is not affiliated with the Department.

(i) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 4. The Department's Division of Aging and Adult Services shall develop a Quality Improvement Consultation Program for Adult Care Homes. The purpose of the Program is to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers. The county department of social services shall be responsible for implementation of the Program with all adult care homes located in the respective county based on a timetable for statewide implementation.

The Division of Aging and Adult Services shall consult with adult care home providers, county departments of social services, consumer advocates, and other interested stakeholders and parties in the development of the Quality Improvement Consultation Program for Adult Care Homes.

The Department shall submit a progress report to the North Carolina Study Commission on Aging and to the Senate Appropriations Committee on Health and Human Services and to the House of Representatives Subcommittee on Health and Human Services on or before April 1, 2006.

The report will address the following topics:

(1) Principles and philosophies that are resident centered and promote independence, dignity, and choice for residents;

(2) Approaches to develop continuous quality improvement with a focus on resident satisfaction and optimal outcomes;

(3) Dissemination of best practice models that have been used successfully elsewhere;

(4) A determination of the availability of standardized instruments, and their use to the extent possible, to assess and measure adult care home performance according to quality of life indicators;

(5) Utilization of quality improvement plans for adult care homes that identify and resolve issues that adversely affect quality of care and services to residents. The plans include agreed upon time frames for completion of improvements and identification of needed resources;

(6) Training required to equip county departments of social services staff to implement the Program;

(7) A distinction of roles between the regulatory role of the Department's Division of Facility Services, and the quality improvement consultation and monitoring responsibilities of the county departments of social services; and

(8) Identification of staffing and other resources needed to implement the Program.

The Division of Aging and Adult Services shall conduct a pilot of the Quality Improvement Consultation Program for Adult Care Homes. No more than four county departments of social services shall participate in the pilot. The Division of Aging and Adult Services shall consider geographic balance and size in carrying out the pilot. At the conclusion of the pilot, the Division of Aging and Adult Services shall make recommendations regarding the effectiveness of the Quality Improvement Consultation Program for Adult Care Homes. If the Division recommends expansion of the pilot to other counties or statewide implementation of the Program, its report shall include the cost and a proposed timetable for implementing these recommendations, including the identification of any necessary statutory and administrative rule changes. The recommendations shall be made to the Secretary of the Department of Health and Human Services, the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Subcommittee.

SECTION 5. The changes to G.S. 131D-2(b)(1a)(d) in section 3.(b) of this bill become effective January 1, 2006. Adult home specialists and their supervisors employed prior to and on the effective date of this sub-subparagraph must complete the required training components or those portions of the training components they have not they have not completed prior to the effective date within twelve months. Section 4 of this act becomes effective July 1, 2005. The remainder of this act is effective when it becomes law.

SENATE BILL 1074:
Facility Quality and Safety Improvements

BILL ANALYSIS

Committee:		**Date:**	May 17, 2005
Introduced by:		**Summary by:**	Ben Popkin
Version:	PCS to First Edition S1074-CSRD		Committee Counsel

SUMMARY: Senate Bill 1074 would amend current statutes and add new statutes to improve quality and safety in home care services, mental health facilities, adult care homes, and certain hospital facilities. The bill would require annual inspections of adult care and mental health facilities by trained inspectors; triennial inspections of home care agencies; increase penalties for violating any applicable State and federal laws and regulations; impose penalties for providing false information during the licensure application process; prohibit the employment of individuals with records of past abusive behavior (as recorded in the Health Care Personnel Registry[1]); modify language relating to the adult care facility penalty review committee; and require that a Department of Health and Human Services, Division of Facility Services hotline be given to all home care agency clients and posted in all adult care and mental health facilities.

BILL ANALYSIS: Senate Bill 1074 would make changes to current statutes governing the licensure, certification and operations of home care services, mental health facilities, adult care homes, and certain hospital facilities. The changes proposed are as follows:

Home Care Agencies – the bill would direct the North Carolina Medical Care Commission to do the following: define the geographic service area in which a home care agency is licensed to operate; adopt rules establishing staff qualifications and training; adopt rules prohibiting the employment of individuals listed on the Health Care Personnel Registry[2] (for past abusive or negligent behavior). The Department would be directed to conduct inspections of home care agencies at least every three years. Agencies would be required to provide all prospective or new home care agency clients with a Division of Facility Services hotline to be called to register any concerns.

Licensure would be shifted to a six month provisional license for new licensees to establish compliance with all applicable rules and statutes. Licenses could then be renewed annually by compliant agencies, and would be terminated for those not serving any clients for a period of 12 months.

Civil penalties for violation of relevant rules and statutes would be doubled from the current amounts and the threshold size for increased penalties would be reduced from ten to seven persons ($500 to $10,000 for programs serving six or fewer persons and $1,000 to $20,000 for programs serving seven or more persons).

Residential Facilities *(adult care homes and facilities for mentally handicapped, developmentally disabled and substance abusers)* - Facilities would be required to post conspicuously in a public place a Division of Facility Services hotline to be called to register any concerns. Licensure would be shifted to a six month provisional license for new licensees to establish compliance with all applicable rules and statutes. Licenses could then be renewed annually by facilities in compliance. Department of social services adult home specialists would complete the required training regimens and would conduct routine monitoring of facilities. In cases of inadequate monitoring by county departments of social

[1] G.S. 131E-256(a)(1).
[2] G.S. 131E-256(a)(1).

services, the Department would be authorized to assume regulatory responsibility of the county's adult care homes. The Division of Facility Services would conduct annual inspections of all adult care homes and adult care units in nursing homes.

Civil penalties for violation of relevant rules and statutes would be doubled from the current amounts and the threshold facility size for increased penalties would be reduced from ten to seven beds ($500 to $10,000 for facilities with six or fewer beds and $1,000 to $20,000 for facilities with seven or more beds). Civil penalties would also be imposed on applicants for licensure who provide false information or omit material information on their licensure application.

The penalty review committee would meet semi-annually to review violations and penalties imposed by the Adult Care Licensure Section and would publish a report of its findings and recommendations for rule or policy changes. Interested parties – the licensed provider, the local department of social services, the residents affected and families or guardians of the residents would be provided notice of committee meetings. The committee would be co-chaired by a member of the Department, outside of the Division of Facility Services and one member not affiliated with the Department.

Division of Aging and Adult Services – The Department's Division of Aging and Adult Services would be directed to develop a Quality improvement Consultation Program for Adult Care Homes. The program would be intended to promote better care and improve quality of life for residents in adult care homes and would be implemented by the county department of social services. The Department would submit a progress report to the North Carolina Study Commission on Aging and to the Senate Appropriations Committee on Health and Human Services and to the House of Representatives Subcommittee on Health and Human Services on or before April 1, 2006. The Division of Aging and Adult Services would conduct a pilot program involving no more than four county departments of social services and make appropriate recommendations to the Secretary of the Department of Health and Human Services, the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services and the House of Representatives Subcommittee on Health and Human Services.

EFFECTIVE DATE: Section 2.(d), calling for annual inspection of 122C residential facilities (for the mentally ill, developmentally disabled, or substance abusers), would be effective on July 1, 2007. Section 3.(b) addressing inspections of Adult Care Homes would be effective January 1, 2006. Section 4 of the bill would be effective July 1, 2005. The remainder of the bill would be effective when it becomes law.

S1074e1-SMRD-CSRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1074
PROPOSED COMMITTEE SUBSTITUTE S1074-PCS35227-RD-20

Short Title: Facility Quality and Safety Improvements. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE STATUTORY CHANGES TO IMPROVE QUALITY AND SAFETY IN HOME CARE SERVICES, MENTAL HEALTH FACILITIES, ADULT CARE HOMES, AND CERTAIN HOSPITAL FACILITIES, AND TO APPROPRIATE FUNDS TO IMPLEMENT THE CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this Part. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care ~~service.~~service including defining the geographic service area in which a home care agency is licensed to operate.

(a2) The Commission shall adopt rules to establish staff qualifications including professional requirements for home care agency staff. The rules may require that one or more staff of an agency be either licensed or certified. The rules may establish minimum training and education qualifications for staff and may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the North Carolina General Statutes provided that the professional board evaluates applicants on a basis that protects the public health, safety, or welfare.

(a3) The Commission shall adopt rules for prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care ~~agencies.~~agencies and shall conduct an inspection of each agency at least every three years."

SECTION 1.(b) G.S. 131E-141 reads as rewritten:

"**§ 131E-141. Inspection.**

(a) The Department shall inspect home care agencies in accordance with rules adopted by the Commission to determine compliance with the provisions of this Part and the rules established by the Commission.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department who make these inspections may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been clients of the agency being inspected unless that client objects in writing to review of that client's records. Physicians, psychiatrists, nurses, and anyone else involved in giving treatment at or through an agency who may be interviewed by representatives of the Department may disclose to these representatives information related to any inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communication between physician and patient," or any other rule of law; provided the client has not made written objection to this disclosure. The agency, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews, except as noted in G.S. 131E-124(c), shall be kept confidential by the Department and not disclosed without written authorization of the client or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning an agency without the consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "`Public records' defined." Prior to releasing any information or allowing any inspections referred to in this section, the client must be advised in writing by the licensed agency that the client has the right to object in writing to release of information or review of the client's records and that by an objection in writing the client may prohibit the inspection or release of the records.

(c) An agency must provide each client with a written notice of the Division of Facility Services hotline number in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services."

SECTION 2.(a) G.S. 122C-23(e) reads as rewritten:

"(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.~~Initial licenses issued under the authority of this section shall be valid for not more than 15 months. Licenses

shall be renewed annually thereafter and shall expire at the end of the calendar year. 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. Licenses for facilities that have not served any clients during the previous 12 months are not eligible for renewal.

The Secretary may issue a provisional license for a period up to six months to a person obtaining the initial license for a facility. The licensee must demonstrate substantial compliance prior to being issued a full license.

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.~~when the noncompliance does not present an immediate threat to the health and safety of the individuals in the licensable facility. 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."

SECTION 2.(b) G.S. 122C-24.1(a) reads as rewritten:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violations Classified. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than ~~two hundred fifty dollars ($250.00)~~ five hundred dollars ($500.00) nor more than ~~five thousand dollars ($5,000)~~ ten thousand dollars

($10,000) for each Type A Violation in facilities or programs that serve ~~nine~~ six or fewer persons. The Department shall impose a civil penalty in an amount not less than ~~five hundred dollars ($500.00)~~ one thousand dollars ($1,000) nor more than ~~ten thousand dollars ($10,000)~~ twenty thousand dollars ($20,000) for each Type A Violation in facilities or programs that serve ~~10~~ seven or more persons.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation."

SECTION 2.(c) G.S. 122C-24.1(b) reads as rewritten:

"(b) Penalties for Failure to Correct Violations Within Time Specified. –

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to ~~two hundred dollars ($200.00)~~four hundred dollars ($400.00) for each day that the deficiency continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) of this section when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which it received a citation during the previous 12 months."

SECTION 2.(d) Effective July 1, 2007, G.S. 122C-25(a) reads as rewritten:

"**§ 122C-25. Inspections; confidentiality.**

(a) The Secretary shall make or cause to be made inspections that the Secretary considers necessary. Facilities licensed under this Article shall be subject to inspection

at all times by the Secretary. All residential facilities as defined in G.S. 122C-3(14)e. shall be inspected on an annual basis.

...."

SECTION 2.(e) G.S. 122C-25 is amended by adding the following new subsection to read:

"**§ 122C-25. Inspections; confidentiality.**

...

(d) All residential facilities, as defined in G.S. 122C-3(14)e. shall ensure that the Division of Facility Services complaint hotline number is posted conspicuously in a public place in the facility."

SECTION 3.(a) G.S. 131D-2(b)(1) reads as rewritten:

"(b) Licensure; inspections. –

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the 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. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted pursuant thereto, the Department shall issue a license for the balance of the calendar year. Licenses ~~issued~~ renewed under the authority of this section shall be valid for one year from the date of ~~issuance~~ renewal 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. The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of one hundred twenty-five dollars ($125.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of one hundred seventy-five dollars ($175.00) plus a nonrefundable annual per-bed fee of six dollars and twenty-five cents ($6.25). A license shall not be renewed if outstanding fees, 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."

SECTION 3.(b) G.S. 131D-2(b)(1a) reads as rewritten:

"(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this ~~subsection,~~subsection:

a. ~~the~~ The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. The Division of Facility Services shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter.

b. ~~In carrying out this requirement, the~~ The Department shall work with county departments of social services to do the routine monitoring in adult care homes in accordance with policy and procedures established by the Division of Facility Services and to have the Division of Facility Services oversee this monitoring and perform any required follow-up ~~inspection called for.~~inspection. The county departments of social services shall document in a written report all on-site visits including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Facility Services written reports of each facility visit within 20 working days of the visit.

c. The Division of Facility Services shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

1. Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.
2. Advising county personnel as to appropriate policies and procedures.
3. Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

d. The county departments of social services' adult home specialists and their supervisors shall complete:

1. Eight hours of pre-basic training within 60 days of employment;

2. Thirty-two hours of basic training within six months of employment;
3. Twenty-four hours of post-basic training within six months of the basic training program;
4. A minimum of eight hours of complaint investigation training within six months of employment; and
5. A minimum of 16 hours of statewide training annually by the Division of Facility Services.

e. 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.

f. 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."

SECTION 3.(c) G.S. 131D-2 is amended by adding the following new subsection to read:

"(j) Adult care homes shall post the Division of Facility Services' complaint hotline number conspicuously in a public place in the facility."

SECTION 3.(d) G.S. 131D-34 reads as rewritten:

"**§ 131D-34. Penalties; remedies.**

(a) Violations Classified. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility which is found to be in violation of requirements of G.S. 131D-21 or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than ~~two hundred fifty dollars ($250.00)~~five hundred dollars ($500.00) nor more than ~~five thousand dollars ($5000)~~ ten thousand dollars ($10,000) for each Type A Violation in homes licensed for ~~nine~~ six or fewer beds. The Department shall impose a civil penalty in an amount not less than ~~five hundred dollars ($500.00)~~ one thousand dollars ($1,000) nor more than ~~ten thousand dollars ($10,000)~~twenty thousand dollars ($20,000) for each Type A Violation in facilities licensed for ~~10~~ seven or more beds.

(2) "Type B Violation" means a violation by a facility of the regulations, standards and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

(b) Penalties for failure to correct violations within time specified.

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to ~~two hundred dollars ($200.00)~~four hundred dollars ($400.00) for each day that the deficiency continues beyond the date specified for correction without just reason for such failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which it received a citation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a

court-appointed temporary manager pursuant to Article 4 of this Chapter.

(c) Factors to be considered in determining amount of initial penalty. In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a resident has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1a) The gravity of the violation, including the probability that death or serious physical harm to a resident will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1b) The gravity of the violation, including the probability that death or serious physical harm to a resident may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131E-265 and other applicable State and federal laws and regulations;

(2a) Efforts by the licensee to correct violations;

(3) The number and type of previous violations committed by the licensee within the past 36 months;

(4) The amount of assessment necessary to insure immediate and continued compliance; and

(5) The number of patients put at risk by the violation.

(c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Secretary shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The penalty review committee;

(2) The local department of social services who is responsible for oversight of the facility involved;

(3) The licensee involved;

(4) The residents affected; and

(5) The family members or guardians of the residents affected.

(c2) Local county departments of social services and Division of Facilities Services personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation.

(d) The Department shall impose a civil penalty on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits material information on the portion of the

licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A Violation.

(e) Any facility wishing to contest a penalty 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 a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(f) Notwithstanding the notice requirements of G.S. 131D-26(b), any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began.

(g) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(g1) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:

(1) The cost of training does not exceed one thousand dollars ($1,000);

(2) The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and

(3) The training is:

a. Specific to the violation;

b. Approved by the Department of Health and Human Services; and

c. Taught by someone approved by the Department and other than the provider.

(h) The Secretary shall establish a penalty review committee within the Department, which shall meet at least semiannually to review violations and penalties imposed by the Adult Care Licensure Section; provide a forum for residents, guardians or families of residents, local department of social services, and providers; and make recommendations to the Department for changes in policy, training, or rules as a result

of its review and publish a report.~~review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E 129 as follows:~~

(1) The Secretary ~~shall:~~ shall administer the work of the Committee and provide notice of its meetings to the following parties involved in the penalties the Committee will be reviewing:

a. The licensed provider; ~~Administer the work of the committee;~~

b. The local department of social services that is responsible for oversight of the facility involved; ~~Ensure provision of departmental staff review;~~

c. The residents affected; and ~~Evaluate the local departments of social services and the Division of Facility Services' penalty recommendations;~~

d. The families or guardians of the residents affected. ~~Ensure that recommendations by the Department are complete and submitted within 60 days of receipt of the initial recommendations from the local departments of social services or the Division of Facility Services; and~~

~~e. Provide written copies of all procedures to:~~

~~1. The penalty review committee;~~

~~2. The local department of social services who is responsible for oversight of the facility involved;~~

~~3. The licensee involved;~~

~~4. The residents affected; and~~

~~5. The families or guardians of the residents affected.~~

(2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:

a. A licensed pharmacist;

b. A registered nurse experienced in long term care;

c. A representative of a nursing home;

d. A representative of an adult care home; and

e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.

(3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be

employed by or own any interest in a nursing home or adult care home.

~~(4) Prior to serving on the committee, each member shall complete a training program provided by the Department of Health and Human Services that covers standards of care and applicable State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.~~

~~(5)~~(4) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.

(5) The Committee shall be cochaired by:

(a) One member of the Department outside of the Division of Facility Services; and

(b) One member who is not affiliated with the Department.

(i) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 4. The Department's Division of Aging and Adult Services shall develop a Quality Improvement Consultation Program for Adult Care Homes. The purpose of the Program is to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers. The county departments of social services shall be responsible for implementation of the Program with all adult care homes located in the respective county, based on a timetable for statewide implementation.

The Division of Aging and Adult Services shall consult with adult care home providers, county departments of social services, consumer advocates, and other interested stakeholders and parties in the development of the Quality Improvement Consultation Program for Adult Care Homes.

The Department shall submit a progress report to the North Carolina Study Commission on Aging and to the Senate Appropriations Committee on Health and Human Services and to the House of Representatives Subcommittee on Health and Human Services on or before April 1, 2006.

The report will address the following topics:

(1) Principles and philosophies that are resident centered and promote independence, dignity, and choice for residents;

(2) Approaches to develop continuous quality improvement with a focus on resident satisfaction and optimal outcomes;

(3) Dissemination of best practice models that have been used successfully elsewhere;

(4) A determination of the availability of standardized instruments, and their use to the extent possible, to assess and measure adult care home performance according to quality of life indicators;

(5) Utilization of quality improvement plans for adult care homes that identify and resolve issues that adversely affect quality of care and

services to residents. The plans include agreed upon time frames for completion of improvements and identification of needed resources;

(6) Training required to equip county departments of social services staff to implement the Program;

(7) A distinction of roles between the regulatory role of the Department's Division of Facility Services, and the quality improvement consultation and monitoring responsibilities of the county departments of social services; and

(8) Identification of staffing and other resources needed to implement the Program.

The Division of Aging and Adult Services shall conduct a pilot of the Quality Improvement Consultation Program for Adult Care Homes. No more than four county departments of social services shall participate in the pilot. The Division of Aging and Adult Services shall consider geographic balance and size in carrying out the pilot. At the conclusion of the pilot, the Division of Aging and Adult Services shall make recommendations regarding the effectiveness of the Quality Improvement Consultation Program for Adult Care Homes. If the Division recommends expansion of the pilot to other counties or statewide implementation of the Program, its report shall include the cost and a proposed time table for implementing these recommendations, including the identification of any necessary statutory and administrative rule changes. The recommendations shall be made to the Secretary of the Department of Health and Human Services, the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Subcommittee on Health and Human Services.

SECTION 5. The changes to G.S. 131D-2(b)(1a)d. in Section 3(b) of this act become effective January 1, 2006. Adult home specialists and their supervisors employed prior to and on the effective date of this sub-subdivision must complete the required training components or those portions of the training components they have not completed prior to the effective date within 12 months. Section 4 of this act becomes effective July 1, 2005. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1161*

Short Title:	Central Registry/MH Beds/Invol. Comm.	(Public)
Sponsors:	Senator Apodaca.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A CENTRAL REGISTRY OF AVAILABLE BEDS IN MENTAL HEALTH FACILITIES TO ASSIST IN THE PLACEMENT OF INDIVIDUALS INVOLUNTARILY COMMITTED TO THE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop a central call registry to assist law enforcement officers and others in identifying available beds in mental health facilities for placement of individuals committed the facilities. The registry may be automated but shall be available for successful access by law enforcement officers at all times. In developing the registry, the Department shall ensure that information on bed availability from mental health facilities that serve involuntary committees is transmitted to the registry and updated daily. The Department shall report on the implementation of the registry to 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 not later than October 1, 2005, and again on March 1, 2006.

SECTION 2. This act becomes effective July 1, 2005.

VISITOR REGISTRATION SHEET

Senate Health Care — **May 18, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carla Steiner	Guilford CFAC 613 Friendsway Rd Greensboro NC 27410
Chris Spence	MHA-Greensboro 330 Green St Greensboro, NC 27401
Luv Dee Sampson	UNC Chapel Hill
Tim Rogers	Assoc. for Home & Hospice Care of NC
Jeff McLeod	Coalition 2001 Governor's Advocacy Council for Persons with Disabilities
Carol D Clayton	NC Council of Community Programs
Jason Lewis	Residential Services, Inc.
AARON ECKARDT	RESIDENTIAL SERVICES INC
RICKY SAMPSON	RESIDENTIAL SERVICES INC.
Doug Harrison	RENU LIFE 501 Forest Hill Dr. Goldsboro, NC 27534
Diane Harrison	Renu Life PO Box 1017 Goldsboro NC 27530

VISITOR REGISTRATION SHEET

Senate Health Care — **May 18, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christy Tronnier	University of NC - Chapel Hill School of Social Work
Florence Ikechukwu	School of Social Work UNC - Chapel Hill
Ikey Kakouras	School of Social Work - UNC - Chapel Hill
Joneeka Watson	UNC-CH School of Social Work
Cassandra Hefner	RN - NCNA - Nurse of the Day
Debbie Barnes	OSBM
Spencer Clark	DHHS/DMHDDSAS
Nancy Thorniley	Arc Moore County Sandhills Children's Center
Betsy Brouwers	DD Consumer
Wendy Russell	The Arc of Moore Co.
Kate Gaston	Mental Health Association in Greensboro

VISITOR REGISTRATION SHEET

Senate Health Care — **May 18, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Hugh Tilson	NCAHA
John Bowdish	AstraZeneca
Lu-Ann Coe	NCPA
Lyn Vick	NCALTCF
M Dam	DFS
Bob Fitzgerald	DHHS/DFS
Gray Bullard	Doctor of Day - NCMS
Seth Bullard	Cannon School
Ryan Lubert	NCMS
Amy Baker	UNC

VISITOR REGISTRATION SHEET

Senate Health Care — **May 18, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ifida Azzarelli	UNC - SoWo
DAVID Swann	Crossroads Behavioral Healthcare
Stephanie Alexander	DHHS - DFS
Jeff Horton	DHHS-DFS
Rob Lewis	NCHCA
Mary Lewis	NCSA
Jennie Dorsett	IDS
DAVID BARNES	Payment Spanning
C C Cochran	ESUCP - C2007
Suzanne Merrill	DHHS/DAAS
Gerri Smith	The Arc of North Carolina/Wake County 4200 Six Forks Rd Raleigh, NC 27609
Lee Hodges	KCLH

VISITOR REGISTRATION SHEET

Senate Health Care — **May 18, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jami Fitzgerald	NCFPC

AGENDA

SENATE HEALTH CARE COMMITTEE
May 25, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. **Welcome and Opening Remarks**

II. **Bills to be Considered**

- **H.B. 916, Hemophilia Drugs/Extend Sunset on Prior Auth., Rep. Gillespie**
- **S.B. 703. Rate and Inflationary Increases/MH Providers Sen. Nesbitt**
- **S.B. 1161, Central Registry/MH Beds/Invol. Comm. Sen. Apodaca**
- **S.B. 42, Home Care Changes Sen. Swindell**
- **H.B. 869, Public Hospital Amendments Rep. Wright**
- **S.B. 489, Cosmetic Art Definitions/Exam Facilities Sen. Cowell**

III. **Other Business**

IV. **Adjournment**

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, May 25, 2005

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

FAVORABLE

S.B. **703** Rate and Inflationary Increases/MH Providers.
Sequential Referral: None
Recommended Referral: Appropriations/Base Budget

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

H.B. **869** Public Hospital Amendments.
Draft Number: 80407
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, May 26, 2005

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

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

S.B. **1161** Central Registry/MH Beds/Invol. Comm.

Draft Number:	85253
Sequential Referral:	None
Recommended Referral:	Appropriations/Base Budget
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Tuesday, May 31, 2005

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

FAVORABLE

S.B. **740** Certificate of Need Amendments.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, June 02, 2005

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

FAVORABLE

H.B.(CS #1) **916** Hemophilia Drugs/Remove Sunset on Prior Auth.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, May 25, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 25, 2005, in Room 544 of the Legislative Office Building, with sixteen members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. Senator Purcell recognized the Doctor of the Day, Dr. Walter Wright of Kinston.

Senator Purcell recognized Senator Rand to present his bill, SB 740, *Certificate of Need Amendments*. He described the effect this bill would have on hospitals, hospices, kidney treatment centers, and HMOs. Senator Malone asked if this bill would weaken the CON process; the response was that it would not, that it strengthens the process. Senator Forrester asked, if a piece of equipment is being replaced, would there be a need for a new CON. The response was no, if the equipment is being replaced and the old one disposed of. Senator Purcell called on Mr. Roger Bone, representing U.S. Oncology, which operates the Raleigh Hematology Center at Rex Hospital, in addition to several other oncology centers. Mr. Bone pointed out that while this organization does not oppose the bill, the provisions of this bill would greatly affect the new oncology center the company is building across from Rex Hospital by limiting it to only one linear accelerator as the building is being constructed, and that he has submitted an amendment to Senator Rand exempting this building from the provisions of the bill, to no avail. Senator Lucas asked why this could not be done. Mr. Bob Fitzgerald, Director of the Division of Facility Services, DHHS, pointed that this bill affects everyone across the state, requiring all centers to apply for a CON before purchasing a linear accelerator. In response to another question from Senator Lucas, Mr. Bone said that U.S. Oncology's original plan called for two linear accelerators, but could put in only one due to a mandated limit of spending $2M per year for such equipment. Senator Kinnaird asked if there is an affiliation between U.S. Oncology and Rex Hospital, the answer was no. She asked what would happen to the oncology unit in Rex Hospital when the other building, just across the street, was completed and accepting patients. Mr. Hugh Tilson, representing the Hospital Association, said that the patients left at Rex Hospital, which already has four linear accelerators, would be ones that the new center do not want to treat or cannot treat. Senator Dannelly asked if there is any other oncology center in the state currently under construction. Ms. Lee Hoffman, Chief of the Certificate of Need Section, clarified the $2M requirement and that there are several providers that are submitting CON requests under the current law, as is U.S. Oncology. Senator Forrester asked what are the chances of U.S. Oncology getting approval for a CON with Rex Hospital just across the street. Ms. Hoffman responded that she did not know, not having read their applications. Senator Bingham moved for a favorable report and the bill passed.

Senator Presnell brought HB. 916, *Hemophilia Drugs/Extent Sunset on Prior Auth.* to the Committee. Senator Dannelly moved for a proposed committee substitute for purposes of discussion. Senator Forrester moved for a favorable report and the bill passed.

Senator Nesbitt presented SB 703, *Rate and Inflationary Increases/MH Providers*. Senator Dannelly moved for a favorable report. The bill passed and was referred to the Appropriations Committee.

Senator Apodaca presented SB 1161, *Central Registry/MH Beds/Invol. Comm.* and outlined the need for this bill. Senator Dannelly moved to adopt a proposed committee substitute. Ms. Lisa Wainwright, Deputy Director for the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse, pointed out that the bill does not include an appropriation for building such a registry, as well as several other problems with such a registry. In addition she said that it is not the function of law enforcement to find a bed for persons being involuntarily committed, that it is the function of the local management entity. Senator Dannelly asked how

long it would take before the LMEs (Local Management Entities) are able to help local law enforcement agencies in making these placements. The response was that there is a requirement for the LMEs to be able to do this by June 30th. Senator Nesbitt questioned as to how well the system will function at that time and why setting up a central registry for crises would be difficult. Ms. Wainwright replied that while information on the number of beds is available for those involuntarily committed, there is no mechanism to update specific bed availability in each facility on a daily basis. Senator Apodaca pointed out that the department already has a web site and that it should not require an extensive amount of money to build a registry and to update it daily or even every two days and to code the beds. Senator Kinnaird asked how much money it would take to build this registry, and if the department could work with the LMEs to build this registry on a statewide basis. Senator Malone asked if the issue is addressed of placing a patient in a bed with no clinical analysis. Senator Apodaca said the Section II of the bill deals with the LMEs and the services they are supposed to provide. One of the services is that a crisis team be available to assist and help with diagnosis. Senator Berger asked why the needed information could not be placed on the department's web page. Senator Garwood moved for a favorable report for the proposed committee substitute, the bill passed and was referred to the Appropriations Committee.

Senator Bingham took the chair while Senator Purcell brought HB 869, *Public Hospital Amendments* to the Committee's attention. Senator Dannelly moved adoption of the proposed committee substitute. Senator Forrester moved for a favorable report and the bill passed.

The meeting adjourned at 12:05 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

Certificate of Need Law
Summary of
Proposed Legislation for 2005 Session

1. Oncology Treatment Centers

   Summary: Eliminate regulation of the development of oncology treatment centers, both medical oncology and radiation oncology, and instead regulate only the acquisition of linear accelerators and simulators.

   Justification: Reduces the number of activities regulated under the CON law and avoids regulation of physician offices that treat patients with chemicals and do not provide radiation treatment. Levels the playing field by requiring both existing and new health service facilities to obtain a certificate of need before acquiring a linear accelerator or simulator rather than just new facilities.

2. Cardiac Catheterization Services

   Summary: Regulate the provision of new cardiac catheterization services and clarify the definition of cardiac catheterization equipment.

   Justification: Previous legislation was intended to regulate the development of new cardiac catheterization programs. However, results of litigation changed the interpretation of the definition of equipment from its ordinary meaning in the medical field. Consequently, many providers could develop these services without a certificate of need or a review of the need for the services, which is contrary to the intent of the statute.

3. Long Term Care Hospitals

   Summary: Control the conversion of acute care beds between use in a certified long term care hospital and a general acute care hospital by amending the definitions of hospital, health service facility and health service facility bed and adding a definition of long term care hospital.

   Justification: Needs for additional acute care beds, including long term acute care beds, are published in the annual State Medical Facilities Plan. The proposed change is needed to assure the inventory for each bed type remains stable during the course of the year, in order to control separately the development of each type of beds.

4. Hospice Offices

   Summary: Regulate the development of each new office of an existing hospice.

   Justification: To be consistent with regulation of additional home health offices and to prevent an existing agency from opening multiple additional offices in neighboring counties without a review to determine the need for those offices.

5. Public Hearing

   Summary: Allow any person to speak at a public hearing who is interested in the projects under review as opposed to only "affected persons."

   Justification: To remove barrier to participation in public hearings and be consistent with provisions for persons who can submit written comments.

6. Health Maintenance Organizations

Summary: Eliminate the exemption that allows health maintenance organizations to establish a new institutional health services, as defined in GS 131E-176(16), without first obtaining a certificate of need.

Justification: The proposed change does not require that a person must obtain a certificate of need prior to establishing an HMO. Rather, the proposed change requires an inpatient facility controlled by an HMO to obtain a certificate of need prior to developing one of the new institutional health services defined in GS 131E-176(16). The reason for the change is to regulate inpatient facilities controlled by HMOs consistent with the regulation of inpatient facilities owned by other health care providers in the State. It should be noted that no inpatient facilities, which are controlled by HMOs, exist in North Carolina to date.

7. Kidney Disease Treatment Center

Summary: Add a definition of kidney disease treatment center.

Justification: These facilities are currently regulated under the CON law but there is no definition in the CON law defining this type of facility. The change adopts the federal definition of kidney disease treatment centers since the Medicare and Medicaid programs reimburse for provision of these services.

8. Update Terms

Summary: Replace "health service area" which is not defined in the law, with "service area" which is defined in the law.

Justification: All references to "health service area" were not changed to "service area" when the definition of service area was added to the law in 1993.

9. Affected Person

Summary: Revise definition of affected person.

Justification: Current definition is not clear as to which residents are affected persons.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 740

Short Title:	Certificate of Need Amendments.	(Public)
Sponsors:	Senators Rand; and Bingham.	
Referred to:	Health Care.	

March 22, 2005

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CERTIFICATE OF NEED LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

(1) "Adult care home" means a facility with seven or more beds licensed under G.S. 131D-2 or Chapter 131E of the General Statutes that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

(1a) **(See note)** "Air ambulance" means aircraft used to provide air transport of sick or injured persons between destinations within the State.

(1b) "Ambulatory surgical facility" means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under

G.S. Chapter 131E, Article 6, Part D, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision (1b) and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.

(1c) "Ambulatory surgical program" means a formal program for providing on a same-day basis those surgical procedures which require local, regional or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to surgery, to be medically unnecessary.

(2) "Bed capacity" means space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(2a) "Bone marrow transplantation services" means the process of infusing bone marrow into persons with diseases to stimulate the production of blood cells.

(2b) "Burn intensive care services" means services provided in a unit designed to care for patients who have been severely burned.

(2c) "Campus" means the adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service facility and related health care entities.

(2d) "Capital expenditure" means an expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase.

~~(2e) "Cardiac angioplasty equipment" means the cardiac catheterization equipment used in surgery for the restoration, repair, or reconstruction of coronary blood vessels.~~

(2f) "Cardiac catheterization equipment" means the equipment ~~required to perform diagnostic procedures or therapeutic intervention in which a catheter is introduced into a vein or artery and threaded through the circulatory system to the heart.~~used to provide cardiac catheterization services.

(2g) "Cardiac catheterization services" means those procedures, excluding pulmonary angiography procedures, in which a catheter is introduced into a vein or artery and threaded through the circulatory system into the heart specifically to diagnose abnormalities in the motion, contraction, and blood flow of the moving heart or to perform surgical therapeutic interventions to restore, repair, or reconstruct the coronary blood vessels of the heart.

(3) "Certificate of need" means a written order which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of such project.

(4) Repealed by Session Laws 1993, c. 7, s. 2.

(5) "Change in bed capacity" means (i) any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(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," 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.

(5b) "Chemical dependency treatment beds" means beds that are licensed 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.

(6) "Department" means the North Carolina Department of Health and Human Services.

(7) To "develop" when used in connection with health services, means to undertake those activities which will result in the offering of institutional health service or the incurring of a financial obligation in relation to the offering of such a service.

(7a) "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

(7b) "Expedited review" means the status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:

a. The review is not competitive.

b. The proposed capital expenditure is less than five million dollars ($5,000,000).

c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.

d. The agency has not determined that a public hearing is in the public interest.

(7c) "Gamma knife" means equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery.

(8), (9) Repealed by Session Laws 1987, c. 511, s. 1.

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, and/or rehabilitative activity that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical management.

(9b) "Health service facility" means a hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; diagnostic center; ~~oncology treatment center; hospice,~~ hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) "Health service facility bed" means a bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; ~~and~~ (ix) adult care home ~~beds.~~beds; and (x) long-term care hospital beds.

(10) "Health maintenance organization (HMO)" means a public or private organization which has received its certificate of authority under Article 67 of Chapter 58 of the General Statutes and which either is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act or:

a. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X ray, emergency and preventive services, and out-of-area coverage;

b. Is compensated, except for copayments, for the provision of the basic health care services listed above to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and

c. Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organizations, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(10a) "Heart-lung bypass machine" means the equipment used to perform extra-corporeal circulation and oxygenation during surgical procedures.

(11) Repealed by Session Laws 1991, c. 692, s. 1.

(12) "Home health agency" means a private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.

"Home health services" means items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and except for paragraph e. of this subdivision, in a place of temporary or permanent residence used as the individual's home as follows:

a. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
b. Physical, occupational or speech therapy;
c. Medical social services, home health aid services, and other therapeutic services;
d. Medical supplies, other than drugs and biologicals and the use of medical appliances;
e. Any of the foregoing items and services which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his home, or which are furnished at such facility while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

(13) "Hospital" means a public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E-77 of the General ~~Statutes.~~Statutes, except long-term care hospitals.

(13a) "Hospice" means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(13b) "Hospice inpatient facility" means a freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual,

and special needs of terminally ill patients and their families in an inpatient setting. For purposes of this Article only, a hospital which has a contractual agreement with a licensed hospice to provide inpatient services to a hospice patient as defined in G.S. 131E-201(4) and provides those services in a licensed acute care bed is not a hospice inpatient facility and is not subject to the requirements in G.S. 131E-176(5)(ii) for hospice inpatient beds.

(13c) "Hospice residential care facility" means a freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.

(14) Repealed by Session Laws 1987, c. 511, s. 1.

(14a) "Intermediate care facility for the mentally retarded" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with mental retardation, autism, cerebral palsy, epilepsy or related conditions.

(14a1) "Kidney disease treatment center" means a facility that is certified as an end-stage renal disease facility by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 405.

(14b) Repealed by Session Laws 1991, c. 692, s. 1.

(14b1) "Linear accelerator" means a machine used to produce ionizing radiation in excess of one million electron volts in the form of a beam of electrons or photons to treat cancer patients.

(14c) "Lithotriptor" means extra-corporeal shock wave technology used to treat persons with kidney stones and gallstones.

(14c1) "Long-term care hospital" means a hospital that has been classified and designated as a long-term care hospital by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 412.

(14d) Repealed by Session Laws 2001-234, s. 2, effective January 1, 2002.

(14e) "Magnetic resonance imaging scanner" means medical imaging equipment that uses nuclear magnetic resonance.

(14f) "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than seven hundred fifty thousand dollars ($750,000). In determining whether the major medical equipment costs more than seven hundred fifty thousand dollars ($750,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making

operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section.

(15) Repealed by Session Laws 1987, c. 511, s. 1.

(15a) "Multispecialty ambulatory surgical program" means a formal program for providing on a same-day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery.

(15b) "Neonatal intensive care services" means those services provided by a health service facility to high-risk newborn infants who require constant nursing care, including but not limited to continuous cardiopulmonary and other supportive care.

(16) "New institutional health services" means any of the following:

a. The construction, development, or other establishment of a new health service facility.

b. The obligation by any person of a capital expenditure exceeding two million dollars ($2,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds two million dollars ($2,000,000).

c. Any change in bed capacity as defined in G.S. 131E-176(5).

d. The offering of dialysis services or home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

e. A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital expenditure amount or the addition of a health service that is to be located in the facility, or portion thereof, that was constructed or developed in the project.

f. The development or offering of a health service as listed in this subdivision by or on behalf of any person:

1. Bone marrow transplantation services.

2. Burn intensive care services.
2a. Cardiac catheterization services.
3. Neonatal intensive care services.
4. Open-heart surgery services.
5. Solid organ transplantation services.

f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:

1. Air ambulance.
~~2. Cardiac angioplasty equipment.~~
3. Cardiac catheterization equipment.
4. Gamma knife.
5. Heart-lung bypass machine.
5a. Linear accelerator.
6. Lithotriptor.
7. Magnetic resonance imaging scanner.
8. Positron emission tomography scanner.
9. Simulator.

g. to k. Repealed by Session Laws 1987, c. 511, s. 1.

l. The purchase, lease, or acquisition of any health service facility, or portion thereof, or a controlling interest in the health service facility or portion thereof, if the health service facility was developed under a certificate of need issued pursuant to G.S. 131E-180.

m. Any conversion of nonhealth service facility beds to health service facility beds.

n. The construction, development or other establishment of a hospice, hospice inpatient facility, or hospice residential care facility;

o. The opening of an additional office by an existing home health agency or hospice within its service area as defined by rules adopted by the Department; or the opening of any office by an existing home health agency or hospice outside its service area as defined by rules adopted by the Department.

p. The acquisition by purchase, donation, lease, transfer, or comparable arrangement by any person of major medical equipment.

q. The relocation of a health service facility from one service area to another.

r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.

s. The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use

in North Carolina prior to the adoption of this provision, if such equipment would otherwise be subject to review in accordance with G.S. 131E-176(16)(f1.) or G.S. 131E-176(16)(p) if it had been acquired in North Carolina.

t. Repealed by Session Laws 2001-242, s. 4, effective June 23, 2001.

u. **(See note)** The construction, development, establishment, increase in the number, or relocation of an operating room or operating rooms, other than the relocation of an operating room or operating rooms within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room is or operating rooms are currently located.

(17) "North Carolina State Health Coordinating Council" means the Council that prepares, with the Department of Health and Human Services, the State Medical Facilities Plan.

(17a) "Nursing care" means:

a. Skilled nursing care and related services for residents who require medical or nursing care;

b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

These are services which are not primarily for the care and treatment of mental diseases.

(17b) "Nursing home facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.

(18) To "offer," when used in connection with health services, means that the person holds himself out as capable of providing, or as having the means for the provision of, specified health services.

~~(18a) "Oncology treatment center" means a facility, program, or provider, other than an existing health service facility that provides services for diagnosis, evaluation, or treatment of cancer and its aftereffects or secondary results and for which the total cost of all the medical equipment utilized by the center, exceeds two hundred fifty thousand dollars ($250,000). In determining whether costs are more than two hundred fifty thousand dollars ($250,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the facility, program, or provider shall be included.~~

~~The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~

(18b) "Open-heart surgery services" means the provision of surgical procedures that utilize a heart-lung bypass machine during surgery to correct cardiac and coronary artery disease or defects.

(19) "Person" means an individual, a trust or estate, a partnership, a corporation, including associations, joint stock companies, and insurance companies; the State, or a political subdivision or agency or instrumentality of the State.

(19a) "Positron emission tomography scanner" means equipment that utilizes a computerized radiographic technique that employs radioactive substances to examine the metabolic activity of various body structures.

(20) "Project" or "capital expenditure project" means a proposal to undertake a capital expenditure that results in the offering of a new institutional health service as defined by this Article. A project, or capital expenditure project, or proposed project may refer to the project from its earliest planning stages up through the point at which the specified new institutional health service may be offered. In the case of facility construction, the point at which the new institutional health service may be offered must take place after the facility is capable of being fully licensed and operated for its intended use, and at that time it shall be considered a health service facility.

(21) "Psychiatric facility" means a public or private facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes and which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(22) "Rehabilitation facility" means a public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent, professional supervision.

(22a) "Replacement equipment" means equipment that costs less than two million dollars ($2,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than two million dollars ($2,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for

the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

(23) Repealed by Session Laws 1991, c. 692, s. 1.

(24) Repealed by Session Laws 1993, c. 7, s. 2.

(24a) "Service area" means the area of the State, as defined in the State Medical Facilities Plan or in rules adopted by the Department, which receives services from a health service facility.

(24a1) "Simulator" means a machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient.

(24b) "Solid organ transplantation services" means the provision of surgical procedures and the interrelated medical services that accompany the surgery to remove an organ from a patient and surgically implant an organ from a donor.

(24c) "Specialty ambulatory surgical program" means a formal program for providing on a same-day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and authorized by its certificate of need.

(25) "State Medical Facilities Plan" means the plan prepared by the Department of Health and Human Services and the North Carolina State Health Coordinating Council, and approved by the Governor. In preparing the Plan, the Department and the State Health Coordinating Council shall maintain a mailing list of persons who have requested notice of public hearings regarding the Plan. Not less than 15 days prior to a scheduled public hearing, the Department shall notify persons on its mailing list of the date, time, and location of the hearing. The Department shall hold at least one public hearing prior to the adoption of the proposed Plan and at least six public hearings after the adoption of the proposed Plan by the State Health Coordinating Council. The Council shall accept oral and written comments from the public concerning the Plan.

(26) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1002, s. 9.

(27) Repealed by Session Laws 1987, c. 511, s. 1."

SECTION 2. G.S. 131E-180 is repealed.

SECTION 3. G.S. 131E-182(a) reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that applications for similar proposals in the same ~~health~~ service area will be reviewed together."

SECTION 4. G.S. 131E-185(a1) reads as rewritten:

"(a1) Except as provided in subsection (c) of this section, there shall be a time limit of 90 days for review of the applications, beginning on the day established by rule as the day on which applications for the particular service in the service area shall begin review.

(1) Any person may file written comments and exhibits concerning a proposal under review with the Department, not later than 30 days after the date on which the application begins review. These written comments may include:
   a. Facts relating to the service area proposed in the application;
   b. Facts relating to the representations made by the applicant in its application, and its ability to perform or fulfill the representations made;
   c. Discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with relevant review criteria, plans, and standards.

(2) No more than 20 days from the conclusion of the written comment period, the Department shall ensure that a public hearing is conducted at a place within the appropriate ~~health~~ service area if one or more of the following circumstances apply; the review to be conducted is competitive; the proponent proposes to spend five million dollars ($5,000,000) or more; a written request for a public hearing is received before the end of the written comment period from an affected party as defined in G.S. 131E-188(c); or the agency determines that a hearing is in the public interest. At such public hearing oral arguments may be made regarding the application or applications under review; and this public hearing shall include the following:
   a. An opportunity for the proponent of each application under review to respond to the written comments submitted to the Department about its application;
   b. An opportunity for any ~~affected person as defined in G.S. 131E-188(c),~~ person, except one of the proponents, to ~~present comments regarding~~ comment on the applications under review;
   c. An opportunity for a representative of the Department, or such other person or persons who are designated by the Department to conduct the hearing, to question each proponent of applications under review with regard to the contents of the application;

   The Department shall maintain a recording of any required public hearing on an application until such time as the Department's final decision is issued, or until a final agency decision is issued pursuant to a contested case hearing, whichever is later; and any person may submit a written synopsis or verbatim statement that contains the oral presentation made at the hearing.

(3) The Department may contract or make arrangements with a person or persons located within each ~~health~~ service area for the conduct of such public hearings as may be necessary. The Department shall publish, in

each ~~health~~ service area, notice of the contracts that it executes for the conduct of those hearings.

(4) Within 15 days from the beginning of the review of an application or applications proposing the same service within the same service area, the Department shall publish notice of the deadline for receipt of written comments, of the time and place scheduled for the public hearing regarding the application or applications under review, and of the name and address of the person or agency that will preside.

(5) The Department shall maintain all written comments submitted to it during the written comment stage and any written submissions received at the public hearing as part of the Department's file respecting each application or group of applications under review by it. The application, written comments, and public hearing comments, together with all documents that the Department used in arriving at its decision, from whatever source, and any documents that reflect or set out the Department's final analysis of the application or applications under review, shall constitute the Department's record for the application or applications under review."

SECTION 5. G.S. 131E-188(c) reads as rewritten:

"(c) The term "affected persons" includes: the applicant; any person residing within the geographic area served or to be served by the applicant; any person who regularly uses health service facilities within that geographic area; health service facilities and health maintenance organizations (HMOs) located in the ~~health~~ service area in which the project is proposed to be located, which provide services similar to the services of the facility under review; health service facilities and HMOs which, prior to receipt by the agency of the proposal being reviewed, have formally indicated an intention to provide similar services to residents of the service area in the future; third party payers who reimburse health service facilities for services in the ~~health~~ service area in which the project is proposed to be located; and any agency which establishes rates for health service facilities or HMOs located in the ~~health~~ service area in which the project is proposed to be located."

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 916*

Committee Substitute Favorable 5/4/05

Short Title: Hemophilia Drugs/Extend Sunset on Prior Auth. (Public)

Sponsors:

Referred to:

March 28, 2005

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE SUNSET FROM THE LAW EXEMPTING 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. Section 2 of S.L. 2003-179 reads as rewritten:

"**SECTION 2.** This act is effective when it becomes law and expires July 1, ~~2006.~~2009."

SECTION 2. This act becomes effective July 1, 2005.

HOUSE BILL 916:
Hemophilia Drugs/Remove Sunset on Prior Auth

BILL ANALYSIS

Committee:	House Health	**Date:**	May 25, 2005
Introduced by:	Rep. Gillespie	**Summary by:**	Shawn Parker
Version:	2nd Edition		Committee Staff

SUMMARY: House Bill 916 extends the sunset from the law exempting antihemophilic factor drugs from prior authorization requirements established by the Department of Health and Human Services under the Medicaid program.

BILL ANALYSIS: Currently the provision in Part 6 of Article 2 of Chapter 108A of the General Statutes that exempts antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders (where there is no generically equivalent drug available) from prior authorization requirements, expires July 1, 2006. If House Bill 916 were enacted, this sunset would be extended until July 1, 2009.

The act would become effective July 1, 2005.

BACKGROUND: 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: Procrit/Epogen; Neopogen; OxyCotin; Growth Hormones; Provigil; Celebrex; Botox; Myobloc, and Arnesp.

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.

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.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 703

Short Title:	Rate and Inflationary Increases/MH Providers.	(Public)
Sponsors:	Senators Nesbitt; Atwater and Holloman.	
Referred to:	Health Care.	

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PROVIDE FOR RATE AND INFLATIONARY INCREASES IN STATE-FUNDED MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES THAT CORRESPOND TO RATE AND INFLATIONARY INCREASES FOR EQUIVALENT MEDICAID SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall include in its rate-setting methodology for State-funded mental health, developmental disabilities, and substance abuse services rate and inflationary increases that correspond to rate and inflationary increases provided for equivalent Medicaid services, such that as rates are increased and adjusted for inflation for Medicaid services, a corresponding rate increase and inflation adjustment applies for equivalent State-funded mental health, developmental disabilities, and substance abuse services. The Department shall ensure that rate and inflationary increases do not result in a reduction in the services provided or in the number of persons eligible for services.

SECTION 2. This act becomes effective July 1, 2005.

SENATE BILL 703:
Rate and Inflationary Increases/MH Providers

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 20, 2005
Introduced by:	Sen. Nesbitt	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 703 would direct the Department of Health and Human Services to include rate and inflationary increases in its rate-setting methodology for State-funded mental health, developmental disabilities, and substance abuse services. The increases would correspond to rate and inflationary increases provided for equivalent Medicaid services.

[As introduced, this bill was identical to H883, as introduced by Rep. Insko, which is currently in House Appropriations.]

CURRENT LAW: The current rate-setting methodology used by the Department of Health and Human Services (DHHS) for State-funded mental health, developmental disabilities, and substance abuse services calls for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance (DMA) to set rates based on the cost findings that Local Management Entities (LMEs) prepare under guidelines put forth by the DHHS Office of the Controller. LMEs are the units that coordinate and provide MH/DD/SAS services on a county or regional basis, throughout the state.

When the DMHDDSAS and DMA have the flexibility to account for inflation (as determined by State appropriations), they add an increase to the services that Medicaid covers and require the LMEs to pay the statewide Medicaid rate for the service. For services that do not have a Medicaid equivalent, the DMHDDSAS and DMA base the rates for services on prior years' actual costs, as set forth in the findings of actual costs prepares by the LMEs. Rates for State-funded services provided in SFY 2005, for example, are based on SFY 2002 costs.

Total funding available to the DMHDDSAS is a set amount fixed in the State budget, regardless of the rate of inflation. So increases in rates typically force the LMEs to purchase fewer units of service or serve fewer individuals. In an effort to maximize service provided per State dollar, LMEs are allowed to negotiate different rates in the place of the statewide rates set for State funded only services.

BILL ANALYSIS: Senate Bill 703 would direct the Department of Health and Human Services to include rate and inflationary increases in its rate-setting methodology for State-funded mental health, developmental disabilities, and substance abuse services. The increases would correspond in amount to rate and inflationary increases provided for equivalent Medicaid services and would apply at the same time that increases to Medicaid services occur.

The bill would direct the Department to ensure that no reduction in services provided or in number of persons eligible for services would result from the rate and inflationary increases implemented.

EFFECTIVE DATE: The act would be effective July 1, 2005.

703e1-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1161*

Short Title:	Central Registry/MH Beds/Invol. Comm.	(Public)
Sponsors:	Senator Apodaca.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A CENTRAL REGISTRY OF AVAILABLE BEDS IN MENTAL HEALTH FACILITIES TO ASSIST IN THE PLACEMENT OF INDIVIDUALS INVOLUNTARILY COMMITTED TO THE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop a central call registry to assist law enforcement officers and others in identifying available beds in mental health facilities for placement of individuals committed the facilities. The registry may be automated but shall be available for successful access by law enforcement officers at all times. In developing the registry, the Department shall ensure that information on bed availability from mental health facilities that serve involuntary committees is transmitted to the registry and updated daily. The Department shall report on the implementation of the registry to 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 not later than October 1, 2005, and again on March 1, 2006.

SECTION 2. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1161*
PROPOSED COMMITTEE SUBSTITUTE S1161-CSSQ-15 [v.3]

5/24/2005 3:39:19 PM

Short Title: Central Registry/MH Beds/Invol. Comm. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A CENTRAL REGISTRY OF AVAILABLE BEDS IN MENTAL HEALTH FACILITIES TO ASSIST IN THE PLACEMENT OF INDIVIDUALS INVOLUNTARILY COMMITTED TO THE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop a central call registry to assist law enforcement officers and others in identifying available beds in mental health facilities for placement of individuals to be involuntarily committed to the facilities. The registry may be automated and shall be available for access by law enforcement officers at all times. In developing the registry, the Department shall ensure that information on beds available in mental health facilities that house involuntarily committed persons is transmitted to the registry and updated daily. The registry shall be implemented not later than January 1, 2006. The Department shall report on the implementation of the registry to 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 not later than October 1, 2005, and again on March 1, 2006.

SECTION 2. G.S. 122C-141 is amended by adding the following new subsection to read:

"(a1.) The area authority, county programs, or persons covered under G.S. 122C-142, to the extent of their involvement with the placement of individuals involuntarily committed to mental health facilities shall be responsible for utilizing a central registry of available beds in mental health facilities as developed by the Department."

SECTION 3. Section 2 of this act becomes effective January 1, 2006. The remainder of this act becomes effective July 1, 2005.

SENATE BILL 1161:
Central Registry/MH Beds/Invol. Comm

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 16, 2005
Introduced by:	Sen. Apodaca	**Summary by:**	Shawn Parker
Version:	First Edition		Committee Staff

SUMMARY: ***Senate Bill 1161 would require the Department of Health and Human Services to develop a central registry of available beds in mental health facilities to assist in the placement of persons to be involuntarily committed.***

The proposed committee substitute requires that the registry be implemented by January 1, 2006 and directs area authorities, county programs, or persons covered under G.S. 122C-142 to utilize the registry as appropriate based on their involvement with the placement of individuals to be involuntarily committed.

CURRENT LAW: Part 7 of Article 5 of Chapter 122C of the General Statutes sets forth the provisions for involuntary commitment of the mentally ill. The policy of the State is to assist individuals with mental illness, developmental disabilities, and substance abuse problems in ways consistent with the dignity, rights, and responsibilities of all North Carolina Citizens. Within available resources it is the obligation of the State and local government to provide services to eliminate, reduce, or prevent the disabling effects of mental illness, developmental disabilities, and substance abuse through a service delivery system designed to meet the needs of clients in the least restrictive available setting, if the least restrictive setting is therapeutically most appropriate to maximize their quality of life.[1] G.S. 122C-252 authorizes the Secretary to designate State Facilities, 24-hour facilities licensed under Chapter 122C, or hospitals licensed under Chapter 131E as facilities for the custody and treatment of involuntary clients.

BILL ANALYSIS: Senate Bill 1161 requires the Department of Health and Human Services to develop a central registry identifying available beds in mental health facilities by January 1, 2006. The registry is to be updated on a daily basis and is required to be available for access by law enforcement officers at all times. The Department must report on the implementation of the registry to the Senate Appropriations Committee on Health and Human Services, the House of Representative Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. The first report must be presented no later than October 1, 2005, and a second report must be presented on March 1, 2006. The bill further directs area authorities, county programs, or persons covered under G.S. 122C-142 to utilize the registry as appropriate based on their involvement with the placement of individuals to be involuntarily committed.

EFFECTIVE DATE: Section 2 of the act, directing area authorities, county programs, or persons covered under G.S. 12C-142 to use the registry, becomes effective on January 1, 2006. The remainder of the act becomes effective July 1, 2005.

S1161-CSSQ-15-v.3

[1] G.S. 122C-2

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 42*

Short Title:	Home Care Changes.	(Public)
Sponsors:	Senators Swindell, Dannelly, Allran; Boseman, Dalton, Purcell, Rand, Thomas, and Tillman.	
Referred to:	Health Care.	

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AND TO APPROPRIATE FUNDS TO INCREASE THE SURVEY CYCLE FOR LICENSED IN-HOME AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission ~~is authorized to~~ may adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules defining geographic service areas and staffing qualifications for licensed home care agencies.

(a3) The Commission shall adopt rules prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(a4) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. G.S. 131E-136 reads as rewritten:

"**§ 131E-136. Definitions.**

As used in this Part, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(1a) "Geographic service area" means the geographic area in which a licensed agency provides home care services.

(2) "Home care agency" means a private or public organization that provides home care services.

(2a) "Home care agency director" means the person having administrative responsibility for the operation of the agency.

(2b) "Home care client" means an individual who receives home care services.

(3) "Home care services" means any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:

a. Nursing care provided by or under the supervision of a registered nurse;

b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home;

c. Medical social services;

d. In-home aide services that involve hands-on care to an individual;

e. Infusion nursing services; and

f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.

The term does not include: health promotion, preventative health and community health services provided by public health departments; maternal and child health services provided by public health departments, by employees of the Department of Health and Human Services under G.S. 130A-124, or by developmental evaluation centers under contract with the Department of Health and Human Services to provide services under G.S. 130A-124; hospitals licensed under Article 5 of Chapter 131E of the General Statutes when providing follow-up care initiated to patients within six months after their discharge from the hospital; facilities and programs operated under the authority of G.S. 122C and providing services within the scope of G.S. 122C; schools, when providing services pursuant to Article 9 of Chapter 115C; the practice of midwifery by a person licensed under Article 10A of Chapter 90 of the General Statutes; hospices licensed under Article 10 of Chapter 131E of the General Statutes when providing care to a hospice patient; an individual who engages solely

in providing his own services to other individuals; incidental health care provided by an employee of a physician licensed to practice medicine in North Carolina in the normal course of the physician's practice; or nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (i) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided.

(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E."

SECTION 3. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§ 131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§ 131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part.

"**§ 131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.

(11) To be informed of supervisory accessibility and availability.

(12) To be advised of the agency's procedures for discharge.

(13) To receive a reasonable response to his or her requests of the agency.

(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"§ 131E-144.4. Notice to client.

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

(1) A copy of the declaration of home care clients' rights.

(2) The address and telephone number for information, questions, or complaints about services provided by the agency.

(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"§ 131E-144.5. Implementation.

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"§ 131E-144.6. Enforcement and investigation.

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint.

"§ 131E-144.7. Confidentiality.

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of five hundred fifty thousand dollars ($550,000) for the 2005-2006 fiscal year and the sum of five hundred fifty thousand dollars ($550,000) for the 2006-2007 fiscal year to increase the survey cycle to every two years for licensed only home care agencies.

SECTION 5. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 6. Section 4 of this act becomes effective July 1, 2005. Section 3 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 42*
PROPOSED COMMITTEE SUBSTITUTE S42-CSSQ-14 [v.1]

5/19/2005 1:56:43 PM

Short Title: Home Care Changes. (Public)

Sponsors:

Referred to:

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(a3) The Commission shall adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§ 131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§ 131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part.

"**§ 131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.

(11) To be informed of supervisory accessibility and availability.

(12) To be advised of the agency's procedures for discharge.

(13) To receive a reasonable response to his or her requests of the agency.

(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"**§ 131E-144.4. Notice to client.**

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

(1) A copy of the declaration of home care clients' rights.

(2) The address and telephone number for information, questions, or complaints about services provided by the agency.

(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"§ 131E-144.5. Implementation.

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"§ 131E-144.6. Enforcement and investigation.

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint.

"§ 131E-144.7. Confidentiality.

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 3. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 4. Section 2 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

SENATE BILL 42:
Home Care Changes

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	May 19, 2005
Introduced by:	Sen. Swindell	**Summary by:**	Shawn Parker Committee Staff
Version:	PCS to First Edition S42-CSSQ-14		

SUMMARY: Senate Bill 42 would amend the Home Care Agency Licensure Act, establish the Home Care Clients' Bill of Rights, and direct the Department of Health and Human Services to study whether any additional "health care facilities" or "health care personnel" should be defined in the Health Care Personnel Registry.

BILL ANALYSIS:

Section 1 of Senate Bill 42 amends G.S. 131E-140 to provide that the North Carolina Medical Care Commission:

- Adopt, amend, and repeal rules necessary for the implementation of the Home Care Clients' Bill of Rights contained in Section 2 of the bill.
- Adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.
- Adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

Section 2 of the bill establishes the Home Care Clients' Bill of Rights by adding Part 3A to the Home Care Agency Licensure Act. The North Carolina Administrative Code (NCAC) contains rules for The Licensing of Home Care Agencies. Clients Rights and Responsibilities are outlined in 10A NCAC 13J .1007. These rights are <u>not</u> currently codified in the North Carolina General Statutes.

- Section 2 of this bill, establishing the Home Care Clients' Bill of Rights, generally mirrors the structure of the Adult Care Home Residents' Bill of Rights (Chapter 131D, Article 3), and the Nursing Home Patients' Bill of Rights (Chapter 131E, Article 6, Part 2). The Adult Care Home Residents' Bill of Rights, the Nursing Home Patient's Bill of Rights, and the Home Care Clients' Bill of Rights all have the following sections in common: Legislative Intent, Definitions, Declaration of Rights, Notice, Enforcement and Investigation, and Confidentiality.
- The title of the Section 10A NCAC 13J .1007 is CLIENT RIGHTS AND RESPONSIBILITIES.
    - Subsection (a) of 10A NCAC 13J .1007 states that, "An agency must provide each client with a written notice of the client's rights and responsibilities in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services. The agency shall maintain documentation showing that all clients have been informed of their rights and responsibilities." This concept is reflected in new G.S. 131E-144.4.
    - Subsection (b) of 10A NCAC 13J .1007 begins, "Clients' rights shall include at a minimum clients' rights to..." The rest of the subsection contains nine (9) clients rights. Although the section heading incorporates the word "RESPONSIBILITIES", subsection (b) which lists the nine (9) clients' rights does <u>not</u> contain the word "responsibilities."

These rights are contained in new G.S. 131E-144.3. Consistent with the subsection of the rules, the subsection of the bill does not contain the word "responsibilities."

  - Subsection (c) of Section .1007 requires an agency to provide clients with a telephone number for information, questions, or complaints; and requires the agency to provide the number for the Division of Facility Services complaint hotline. This subsection also specifies that DFS will investigate allegations of non-compliance with the rules. The provisions of this subsection are represented in new G.S. 131E-144.4 and G.S. 131E-144.6.
  - Subsection (d) of Section .1007 requires an agency to investigate, within 72 hours, complaints made to the agency by a client or the client's family, an to document both the existence of the complaint and the resolution of the complaint. This provision is represented in new G.S. 131E-144.6(d).

- The Nursing Home Patients' Bill of Rights outlines 16 rights, the Adult Care Home Residents' Bill of Rights outlines 17 rights, and the NCAC currently outlines 9 home care client rights. This bill contains 14 rights. All nine (9) client rights that are contained in the NCAC are represented in the bill, although the wording may have been modified or expanded. Rights contained in subsections 2, 3, 6, 13, and 14 under new G.S. 131E-144.3 are not listed in the NCAC, but mirror the Bills of Rights for residents in adult care homes and patients in nursing homes.

Section 3 requires the Department to study whether there are any additional "health care facilities" (G.S. 131E-256(b)) and "health care personnel" (G.S. 131-256(c)) that should be listed in the definitions contained in the Health Care Personnel Registry (G.S. 131E-256). The bill requires the Department to report findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

EFFECTIVE DATE: Section 2 of the Senate Bill 42, which establishes the Home Care Clients' Bill of Rights, becomes effective January 1, 2006, and the remainder of the bill becomes effective when it becomes law.

BACKGROUND: Recommendations 3, 4, and 5 contained in the North Carolina Study Commission on Aging's report to the Governor and the 2005 Regular Session of the 2005 General Assembly are represented in the bill

S0042e1-SMSQ-CSSQ-14

HOUSE BILL 869

Short Title:	Public Hospital Amendments.	(Public)
Sponsors:	Representative Wright.	
Referred to:	Health.	

March 23, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY AND AMEND THE CONFLICT OF INTEREST LAW FOR PUBLIC HOSPITALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-14.2 reads as rewritten:

"**§ 131E-14.2. Conflict of interest.**

(a) No member of the board of directors or employee of a public hospital, as defined in G.S. 159-39(a), or that person's spouse shall do either of the following:

(1) Acquire any interest, direct or indirect, in any hospital facility or in any property included or planned to be included in a hospital facility.

(2) Have any direct interest ~~interest, direct or indirect,~~ in any contract or proposed contract for materials or services to be furnished or used in connection with any hospital facility, except an employment contract for an employee. This restriction shall not apply to any contract, undertaking, or other transaction with a bank or banking institution, savings and loan association or public utility in the regular course of its business provided that the contract, undertaking, or other transaction shall be authorized by the board by specific resolution on which no director having ~~an interest, direct or indirect, shall vote.~~direct interest shall vote.

(b) The fact that a person or that person's spouse owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have ~~an "interest, direct or indirect"~~ a "direct interest" as this phrase is used in subsection (a) of this section; provided that, in order for the exception to apply, the contract, undertaking, or other transaction shall be authorized by the board of directors by specific resolution on which no director or employee having an interest, direct or indirect, shall vote.

(c) If a member of the board of directors or an employee of a public hospital or that person's spouse owns or controls an interest, direct or indirect, in any property included or planned to be included in any hospital facility, the member of the board of directors or the employee shall immediately disclose the same in writing to the board and the disclosure shall be entered upon the minutes of the board. Failure to disclose shall constitute misconduct in office and shall be grounds for removal.

(c1) Subsection (a) of this section shall not apply if the director or employee is not involved in making or administering the contract. A director or employee is involved in administering a contract if the director or employee oversees the performance of or interprets the contract. A director or employee is involved in making a contract if the director or employee participates in the development of specifications or terms or in the preparation or award of the contract. A director or employee is not involved in making or administering a contract solely because of the performance of ministerial duties related to the contract. A director is also involved in making a contract if the board of directors takes action on the contract, whether or not the director actually participates in that action, unless the contract is approved under an exception to this section under which the director is allowed to benefit and is prohibited from voting.

(d) Subsection (a) of this section shall not apply to any member of the board of directors of a public hospital if (i) the undertaking or contract or series of undertakings or contracts between the public hospital and one of its officials is approved by specific resolution of the ~~governing body~~ board adopted in an open and public meeting and recorded in its ~~minutes~~ minutes; (ii) the official entering into the contract or undertaking with the public hospital does not in an official capacity participate in any way or vote; and (iii) the amount does not exceed twelve thousand five hundred dollars ($12,500) for medically related services and twenty-five thousand dollars ($25,000) for other goods or services within a 12-month period; ~~and (ii) the official entering into the contract or undertaking with the public hospital does not in an official capacity participate in any way or vote.~~or the contract is for medically related services that are provided by a director who serves on the board as an ex officio representative of the hospital medical staff pursuant to a hospital bylaw adopted prior to January 1, 2005, or that are provided by the spouse of that director.

(e) Subsection (a) of this section shall not apply to any employment relationship between a public hospital and the spouse of a member of the board of directors of the public hospital.

(f) A contract entered into in violation of this section is void. A contract that is void under this section may continue in effect until an alternative can be arranged when: (i) immediate termination would result in harm to the public health or welfare, and (ii) the continuation is approved as provided in this subsection. A public hospital that is a party to the contract may request approval to continue contracts under this subsection from the chairman of the Local Government Commission. Approval of continuation of contracts under this subsection shall be given for the minimum period necessary to protect the public health or welfare."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 869
PROPOSED SENATE COMMITTEE SUBSTITUTE H869-PCS80407-LB-53

Short Title: Public Hospital Amendments/Downtown Facility. (Public)

Sponsors:

Referred to:

March 23, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY AND AMEND THE CONFLICT OF INTEREST LAW FOR PUBLIC HOSPITALS AND TO EXTEND A SPECIAL DEADLINE FOR EXEMPT ADULT HOUSING FACILITIES LOCATED IN A DOWNTOWN AREA AND BEING RELOCATED DUE TO A MAJOR ECONOMIC DEVELOPMENT PROJECT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-14.2 reads as rewritten:

"**§ 131E-14.2. Conflict of interest.**

(a) No member of the board of directors or employee of a public hospital, as defined in G.S. 159-39(a), or that person's spouse shall do either of the following:

(1) Acquire any interest, direct or indirect, in any hospital facility or in any property included or planned to be included in a hospital facility.

(2) Have any direct interest ~~interest, direct or indirect,~~ in any contract or proposed contract for materials or services to be furnished or used in connection with any hospital facility, except an employment contract for an employee. This restriction shall not apply to any contract, undertaking, or other transaction with a bank or banking institution, savings and loan association or public utility in the regular course of its business provided that the contract, undertaking, or other transaction shall be authorized by the board by specific resolution on which no director having ~~an interest, direct or indirect, shall vote.~~direct interest shall vote.

(b) The fact that a person or that person's spouse owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have ~~an "interest, direct or indirect"~~ a "direct interest" as this phrase is used in subsection (a) of this section; provided that, in order for the exception to apply, the

contract, undertaking, or other transaction shall be authorized by the board of directors by specific resolution on which no director or employee having an interest, direct or indirect, shall vote.

(c) If a member of the board of directors or an employee of a public hospital or that person's spouse owns or controls an interest, direct or indirect, in any property included or planned to be included in any hospital facility, the member of the board of directors or the employee shall immediately disclose the same in writing to the board and the disclosure shall be entered upon the minutes of the board. Failure to disclose shall constitute misconduct in office and shall be grounds for removal.

(c1) Subsection (a) of this section shall not apply if the director or employee is not involved in making or administering the contract. A director or employee is involved in administering a contract if the director or employee oversees the performance of or interprets the contract. A director or employee is involved in making a contract if the director or employee participates in the development of specifications or terms or in the preparation or award of the contract. A director or employee is not involved in making or administering a contract solely because of the performance of ministerial duties related to the contract. A director is also involved in making a contract if the board of directors takes action on the contract, whether or not the director actually participates in that action, unless the contract is approved under an exception to this section under which the director is allowed to benefit and is prohibited from voting.

(d) Subsection (a) of this section shall not apply to any member of the board of directors of a public hospital if (i) the undertaking or contract or series of undertakings or contracts between the public hospital and one of its officials is approved by specific resolution of the ~~governing body~~ board adopted in an open and public meeting and recorded in its ~~minutes~~ minutes; (ii) the official entering into the contract or undertaking with the public hospital does not in an official capacity participate in any way or vote; and (iii) the amount does not exceed twelve thousand five hundred dollars ($12,500) for medically related services and twenty-five thousand dollars ($25,000) for other goods or services within a 12-month period; ~~and (ii) the official entering into the contract or undertaking with the public hospital does not in an official capacity participate in any way or vote.~~or the contract is for medically related services that are provided by a director who serves on the board as an ex officio representative of the hospital medical staff pursuant to a hospital bylaw adopted prior to January 1, 2005, or that are provided by the spouse of that director.

(e) Subsection (a) of this section shall not apply to any employment relationship between a public hospital and the spouse of a member of the board of directors of the public hospital.

(f) A contract entered into in violation of this section is void. A contract that is void under this section may continue in effect until an alternative can be arranged when: (i) immediate termination would result in harm to the public health or welfare, and (ii) the continuation is approved as provided in this subsection. A public hospital that is a party to the contract may request approval to continue contracts under this subsection from the chairman of the Local Government Commission. Approval of continuation of

contracts under this subsection shall be given for the minimum period necessary to protect the public health or welfare."

SECTION 2. Section 3(a) of S.L. 2004-2 reads as rewritten:

"**SECTION 3.(a)** In applying to a "specially impacted adult care home", Section 11.69(b2) of S.L. 1997-443, as enacted by Section 3 of S.L. 2001-234, "June 1, 2004" shall be read as "~~June 1, 2005~~ June 1, 2006", and "December 1, 2004" shall be read as "~~December 1, 2005~~ December 1, 2006".

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 489

Short Title:	Cosmetic Art Definitions/Exam Facilities.	(Public)
Sponsors:	Senators Cowell, Kerr; and Snow.	
Referred to:	Health Care.	

March 15, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS TO CLARIFY CERTAIN DEFINITIONS UNDER THE NORTH CAROLINA COSMETIC ART ACT, TO APPROVE EXAMINATION FACILITIES, AND TO SET LIMITS FOR FAILED CANDIDATES SEEKING TO RETAKE AN EXAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88B-2 reads as rewritten:

"**§ 88B-2. Definitions.**

The following definitions apply in this Chapter:

(1) Apprentice. – A person who is not a manager or operator and who is engaged in learning the practice of cosmetic art under the direction and supervision of a cosmetologist.

(2) Board. – The North Carolina Board of Cosmetic Art Examiners.

(3) Booth. – A workstation located within a licensed cosmetic art shop that is operated primarily by one individual in performing cosmetic art services for consumers.

(4) Booth renter. – A person who rents a booth in a cosmetic art shop.

(5) Cosmetic art. – All or any part or combination ~~of: (i) the systematic massaging with the hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, and marcelling the hair, and the use of electricity for stimulating growth of hair.~~of cosmetology, esthetics, or manicuring.

(6) Cosmetic art school. – Any building or part thereof where cosmetic art is taught.

(7) Cosmetic art shop. – Any building or part thereof where cosmetic art is practiced for pay or reward, whether direct or indirect.

(8) Cosmetologist. – Any individual who is licensed to practice all parts of cosmetic art.

(8a) Cosmetology. – The act of arranging, dressing, curling, waving, cleansing, cutting, singeing, bleaching, coloring, or similar work upon the hair of a person by any means, including the use of hands, mechanical or electrical apparatus, or appliances or by use of cosmetic or chemical preparations or antiseptics.

(9) Cosmetology teacher. – An individual licensed by the Board to teach all parts of cosmetic art.

(10) Esthetician. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes skin care.

(11) Esthetician teacher. – An individual licensed by the Board to teach only that part of cosmetic art that constitutes skin care.

(11a) Esthetics. – Refers to any of the following practices: giving facials; applying makeup; performing skin care; removing superfluous hair from the body of a person by use of depilatories, tweezers, or waxing; applying eyelashes to a person, including the application of brow or lash color; beautifying the face, neck, arms, or upper part of the human body by use of cosmetic preparations, antiseptics, tonics, lotions, or creams; surface massaging in relation to skin care; or cleaning or stimulating the face, neck, ears, arms, hands, bust, torso, legs, or feet of a person by means of hands, devices, apparatus, or appliances along with the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

(12) Manicuring. – The care and treatment of the fingernails, toenails, cuticles on fingernails and toenails, and the hands and feet, including the decoration of the fingernails and the application of nail extensions and artificial nails. The term "manicuring" shall not include the treatment of pathologic conditions.

(13) Manicurist. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes manicuring.

(14) Manicurist teacher. – An individual licensed by the Board to teach manicuring.

(15) Shampooing. – The application and removal of commonly used, room temperature, liquid hair cleaning and hair conditioning products. Shampooing does not include the arranging, dressing, waving, coloring, or other treatment of the hair."

SECTION 2. G.S. 88B-18 reads as rewritten:

"**§ 88B-18. Examinations.**

(a) Each applicant for any examination shall file an application with the Board, on a form approved by the Board, which shall be verified by the applicant under oath,

and the applicant shall pay the required examination fee. Applications shall be filed at least 30 days before the requested examination date.

(b) Each examination shall have both a practical and a written portion.

(c) Examinations for applicants for apprentice, cosmetologist, teacher, esthetician, and manicurist licenses shall be given in at least three locations in the State that are geographically scattered. The examinations shall be administered in ~~the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. The Board shall reimburse an institution, if requested, for the use of its facilities in administering examinations.~~Board-approved facilities.

(d) An applicant for a ~~cosmetologist~~ cosmetologist, esthetician, manicurist, or teacher's license who fails to pass the examination three times may not reapply to take the examination again until after the applicant has successfully completed any additional requirements prescribed by the Board."

SECTION 3. G.S. 88B-9 reads as rewritten:

"**§ 88B-9. Qualifications for licensing as an esthetician.**

The Board shall issue a license to practice as an esthetician to any individual who meets all of the following requirements:

(1) Successful completion of at least 600 hours of an ~~esthetician~~ esthetics curriculum in an approved cosmetic art school.

(2) Passage of an examination conducted by the Board.

(3) Payment of the fees required by G.S. 88B-20."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 489
PROPOSED COMMITTEE SUBSTITUTE S489-CSSQ-18 [v.1]

5/24/2005 4:36:07 PM

Short Title: Cosmetic Art Definitions/Exam Facilities. (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS TO CLARIFY CERTAIN DEFINITIONS UNDER THE NORTH CAROLINA COSMETIC ART ACT, AND TO SET LIMITS FOR FAILED CANDIDATES SEEKING TO RETAKE AN EXAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88B-2 reads as rewritten:

"**§ 88B-2. Definitions.**

The following definitions apply in this Chapter:

(1) Apprentice. – A person who is not a manager or operator and who is engaged in learning the practice of cosmetic art under the direction and supervision of a cosmetologist.

(2) Board. – The North Carolina Board of Cosmetic Art Examiners.

(3) Booth. – A workstation located within a licensed cosmetic art shop that is operated primarily by one individual in performing cosmetic art services for consumers.

(4) Booth renter. – A person who rents a booth in a cosmetic art shop.

(5) Cosmetic art. – All or any part or combination ~~of: (i) the systematic massaging with the hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, and marcelling the hair, and the use of electricity for stimulating growth of hair.~~of cosmetology, esthetics, or manicuring.

(6) Cosmetic art school. – Any building or part thereof where cosmetic art is taught.

(7) Cosmetic art shop. – Any building or part thereof where cosmetic art is practiced for pay or reward, whether direct or indirect.

(8) Cosmetologist. – Any individual who is licensed to practice all parts of cosmetic art.

(8a) Cosmetology. – The act of arranging, dressing, curling, waving, cleansing, cutting, singeing, bleaching, coloring, or similar work upon the hair of a person by any means, including the use of hands, mechanical or electrical apparatus, or appliances or by use of cosmetic or chemical preparations or antiseptics.

(9) Cosmetology teacher. – An individual licensed by the Board to teach all parts of cosmetic art.

(10) Esthetician. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes skin care.

(11) Esthetician teacher. – An individual licensed by the Board to teach only that part of cosmetic art that constitutes skin care.

(11a) Esthetics. – Refers to any of the following practices: giving facials; applying makeup; performing skin care; removing superfluous hair from the body of a person by use of depilatories, tweezers, or waxing; applying eyelashes to a person, including the application of brow or lash color; beautifying the face, neck, arms, or upper part of the human body by use of cosmetic preparations, antiseptics, tonics, lotions, or creams; surface massaging in relation to skin care; or cleaning or stimulating the face, neck, ears, arms, hands, bust, torso, legs, or feet of a person by means of hands, devices, apparatus, or appliances along with the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

(12) Manicuring. – The care and treatment of the fingernails, toenails, cuticles on fingernails and toenails, and the hands and feet, including the decoration of the fingernails and the application of nail extensions and artificial nails. The term "manicuring" shall not include the treatment of pathologic conditions.

(13) Manicurist. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes manicuring.

(14) Manicurist teacher. – An individual licensed by the Board to teach manicuring.

(15) Shampooing. – The application and removal of commonly used, room temperature, liquid hair cleaning and hair conditioning products. Shampooing does not include the arranging, dressing, waving, coloring, or other treatment of the hair."

SECTION 2. G.S. 88B-18 reads as rewritten:

"**§ 88B-18. Examinations.**

(a) Each applicant for any examination shall file an application with the Board, on a form approved by the Board, which shall be verified by the applicant under oath,

and the applicant shall pay the required examination fee. Applications shall be filed at least 30 days before the requested examination date.

(b) Each examination shall have both a practical and a written portion.

(c) Examinations for applicants for apprentice, cosmetologist, teacher, esthetician, and manicurist licenses shall be given in at least three locations in the State that are geographically scattered. The examinations shall be administered in the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. The Board shall reimburse an institution, if requested, for the use of its facilities in administering examinations.

(d) An applicant for a ~~cosmetologist~~ cosmetologist, esthetician, manicurist, or teacher's license who fails to pass the examination three times may not reapply to take the examination again until after the applicant has successfully completed any additional requirements prescribed by the Board."

SECTION 3. G.S. 88B-9 reads as rewritten:

"**§ 88B-9. Qualifications for licensing as an esthetician.**

The Board shall issue a license to practice as an esthetician to any individual who meets all of the following requirements:

(1) Successful completion of at least 600 hours of an ~~esthetician~~ esthetics curriculum in an approved cosmetic art school.

(2) Passage of an examination conducted by the Board.

(3) Payment of the fees required by G.S. 88B-20."

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

SENATE BILL 489:
Cosmetic Art Definitions/Exam Provisions

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senators Cowell and Kerr
Date:	May 24, 2005	**Summary by:**	Shawn Parker
Version:	PCS to 1st edition		Committee Staff

SUMMARY: Senate Bill 489 amends the Cosmetic Art Act as follows:

- *Clarifies the definition of Cosmetic Art.*
- *Provides definitions for the terms "Cosmetology" and "Esthetics"*
- *Expands certain examination provisions of the act to include manicurists, estheticians, and cosmetology teachers.*

The proposed committee substitute eliminates the provision in the original bill that authorized the North Carolina Board of Cosmetic Art Examiners to approve facilities for licensure examination.

CURRENT LAW: The practice of cosmetic art is regulated by a Board of Cosmetic Art Examiners. Cosmetic art is defined as all or any part or combination of: (i) the systemic massaging with hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, marcelling the hair, and the use of electricity for stimulating growth of hair. The terms cosmetology and esthetics are not defined.

Current law provides that cosmetology examinations must be administered in the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. If a cosmetology applicant fails the licensure examination three times, the applicant may not reapply to take the examination until the applicant successfully completes additional requirements.

BILL ANALYSIS: Senate Bill 489 would define cosmetic art as cosmetology, esthetics, or manicuring and would define cosmetology and esthetics as follows:

- "Cosmetology" would generally mean acts relating to hair cutting, coloring, or styling.
- "Esthetics" would generally mean acts relating to skin care and makeup, including waxing.

Senate Bill 489 also expands the examination provision regarding reapplying for examination of the act to include manicurists, estheticians, and cosmetology teachers.

The act is effective when it becomes law.

S489-SMSQ-002

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 25, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thom Mansfield	NC Medical Board
Hugh Tilson	NCHA
David Barnes	Poyner + Spruill LLP
[illegible]	JD/AL, P.A.
[illegible]	NCPA
Angie Hanes	Haynsworth
John Bowdish	AstraZeneca
Ken Melton	D.O.R.
Gary Salamido	GSK
[illegible]	VS
Steve Keene	NC Medical Society

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 25, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MICHAEL CROWELL	NC ADV. COUNCIL ON GASTROINTESTINAL ENDOSCOPY
GEORGE LAWRENCE	" " "
JOHN GOODMAN	ALLS'T ASSOCIATES
[illegible]	[illegible]
DAVID CHACKET	WILD FRONTIER
[illegible]	Drucker & Falk
[illegible]	NCMS
FRAN PRESTON	NCRMA
LAURIE SMALLWOOD	Wal-Mart
ANDY ELLEN	NCRMA
TOMMY SUTER	WYETH

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 25, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Margaret Brooks	NCFPC
Jessica Sage	NCFPC
Paula A. Wolf	PPAS
Colleen Kochanek	NCCEP
[illegible]	DFS/DHHS
Bob Fitzgerald	DFS/DHHS
[illegible]	Bone & Assoc.
[illegible]	Bone & Asso.
Lu Hodge	KCCH
Laura Garland	Wakemed
[illegible]	GOVERNORS OFFICE

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 25, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nancy Joyce	DFS -
Aggie Gwatti Cooley	DHAS / DFS
FRED WADDLE	Eastern Seals UCP NC
Sally Cameron	NC Psychological Assoc & Coalition 2001
[illegible]	Capitol Group
[illegible]	Capitol Group
Walter L. Wright	Doctor's Day
Jim Edgerton	AHHC
Linwood Jones	NCHA
Lisa Wannamaker	DMHDDSAS
[illegible]	NMRS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 25, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug VanEssen	NC State Board of Cosmetic Art
Kristi Lovejoy	NC Community College System
	Bar Assn
Laura Garland	WakeMed Hospital
Kathleen Edwards	UNC-CH Legis Reporting Service
Evelyn Sanders	Dorothea Dix Hospital
	NCHA - CZ001
	NC Council
	DMA
ANN LOVE	DUHS

Senate Health Care Committee
Wednesday, June 1, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 42	**Home Care Changes.**	**Senator Swindell IV**
SB 268	**Public Laws - 2.**	**Senator Purcell**
SB 489	**Cosmetic Art Definitions/Exam Facilities.**	**Senator Cowell**
SB 1020	**Restaurants/Provide Info on Use of Peanuts.**	**Senator Graham**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

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

Wednesday, June 01, 2005

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

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

S.B. **268** Public Laws - 2.

Draft Number:	PCS 65332
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, June 1, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 1, 2005, in Room 544 of the Legislative Office Building, with eleven members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator William R. Purcell, Co-Chairs, welcomed the committee members and introduced the pages.

Due to the crossover deadline, Senator Stan Bingham, Co-Chair, asked for a motion to allow staff to make technical corrections, which passed unanimously.

Senator Bingham introduced Senator Swindell to present Senate Bill 42, ***Home Care Changes***, to the committee. A motion to hear the Proposed Committee Substitute was brought forward, and passed. Senator Swindell stated the bill would amend the Home Care Agency Licensure Act and establish a home care client's Bill of Rights. It directs the Department of Health and Human Services (DHHS) to study whether any additional health care facilities or health care personnel should be defined in the health care personnel registry. The bill came from the Commission on Aging after extensive conversation and debate. It is supported by the industry. Jim Edgerton, with The Association for Home & Hospice Care Government Relations Director, stated they do support the bill and worked with the Aging Study Commission to get the legislation adopted. Senator Dannley stated he had served on that commission and moved for a favorable report. The motion being unfavorable as to bill, but favorable as to Proposed Committee Substitute with a sequential referral to Appropriation/Base Budget. The bill passed.

Senator Purcell presented his bill, Senate Bill 268, ***Public Laws - 2***, asking for a motion to hear the Proposed Committee Substitute. The motion passed. Senator Purcell reminded everyone about the E.coli infection believed to have come from the petting zoo at the 2004 NC State Fair causing a number of children to developed severe problems, Hemolytic Uremic Syndrome (HUS). Senator Purcell stated HUS was an awful disease and many of the victims were lucky to survive. The family of one of the victims, Aedin Grey, came to see about some preventive legislation, so it was named in her honor. The bill directs the Commission of Agriculture to adopt rules to establish sanitation rules and to adopt rules for the permitting requirements for animal exhibitions. This bill applies to the state fair and forty-five county or local fairs held throughout the state. Senator Forrester asked if the bill applies to zoos. Senator Purcell stated that so far the bill only applies to fairs. Ben Popkin, Staff Attorney, stated this bill requires physical contact between the animals and humans but he stated he would be glad to explore how that would interact with zoos having a petting zoo area. Senator Forrester moved for a favorable report, unfavorable as to the bill, but favorable as to Proposed Committee Substitute. The bill passed.

Senator Cowell presented her bill, SB 489, ***Cosmetic Art Definitions/Exam Facilities***. Senator Dannely made the motion to hear the Proposed Committee Substitute, which passed. Senator Cowell stated that since she was up before this committee they have had more conversations with the Community Colleges, the NC Cosmetology Board, and the Medical Board to make some changes. The bill clarifies some definitions and adds the flexibility for Community Colleges to choose both the community colleges facilities and private facilities for testing for cosmetology. There is a section on the board membership of the Cosmetology Board adding one position increasing the membership from six to seven members. Senator Forrester asked if this increases the scope of practice. Senator Cowell stated it has only added esthetician, a person who does facials. It does not get into anything medical. Senator Jacumin moved for a favorable report. The motion was unfavorable to bill, but favorable to the Proposed Committee Substitute. The bill passed.

The meeting adjourned at 11:30 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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 42*

Short Title:	Home Care Changes.	(Public)
Sponsors:	Senators Swindell, Dannelly, Allran; Boseman, Dalton, Purcell, Rand, Thomas, and Tillman.	
Referred to:	Health Care.	

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AND TO APPROPRIATE FUNDS TO INCREASE THE SURVEY CYCLE FOR LICENSED IN-HOME AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission ~~is authorized to~~ may adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules defining geographic service areas and staffing qualifications for licensed home care agencies.

(a3) The Commission shall adopt rules prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(a4) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. G.S. 131E-136 reads as rewritten:

"**§ 131E-136. Definitions.**

As used in this Part, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(1a) "Geographic service area" means the geographic area in which a licensed agency provides home care services.

(2) "Home care agency" means a private or public organization that provides home care services.

(2a) "Home care agency director" means the person having administrative responsibility for the operation of the agency.

(2b) "Home care client" means an individual who receives home care services.

(3) "Home care services" means any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:

a. Nursing care provided by or under the supervision of a registered nurse;

b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home;

c. Medical social services;

d. In-home aide services that involve hands-on care to an individual;

e. Infusion nursing services; and

f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.

The term does not include: health promotion, preventative health and community health services provided by public health departments; maternal and child health services provided by public health departments, by employees of the Department of Health and Human Services under G.S. 130A-124, or by developmental evaluation centers under contract with the Department of Health and Human Services to provide services under G.S. 130A-124; hospitals licensed under Article 5 of Chapter 131E of the General Statutes when providing follow-up care initiated to patients within six months after their discharge from the hospital; facilities and programs operated under the authority of G.S. 122C and providing services within the scope of G.S. 122C; schools, when providing services pursuant to Article 9 of Chapter 115C; the practice of midwifery by a person licensed under Article 10A of Chapter 90 of the General Statutes; hospices licensed under Article 10 of Chapter 131E of the General Statutes when providing care to a hospice patient; an individual who engages solely

in providing his own services to other individuals; incidental health care provided by an employee of a physician licensed to practice medicine in North Carolina in the normal course of the physician's practice; or nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (i) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided.

(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E."

SECTION 3. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§ 131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§ 131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part.

"**§ 131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.

(11) To be informed of supervisory accessibility and availability.

(12) To be advised of the agency's procedures for discharge.

(13) To receive a reasonable response to his or her requests of the agency.

(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"§ 131E-144.4. Notice to client.

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

(1) A copy of the declaration of home care clients' rights.

(2) The address and telephone number for information, questions, or complaints about services provided by the agency.

(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"§ 131E-144.5. Implementation.

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"§ 131E-144.6. Enforcement and investigation.

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint.

"§ 131E-144.7. Confidentiality.

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of five hundred fifty thousand dollars ($550,000) for the 2005-2006 fiscal year and the sum of five hundred fifty thousand dollars ($550,000) for the 2006-2007 fiscal year to increase the survey cycle to every two years for licensed only home care agencies.

SECTION 5. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 6. Section 4 of this act becomes effective July 1, 2005. Section 3 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 42*
PROPOSED COMMITTEE SUBSTITUTE S42-CSSQ-14 [v.1]

5/19/2005 1:56:43 PM

Short Title: Home Care Changes. (Public)

Sponsors:

Referred to:

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(a3) The Commission shall adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§ 131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§ 131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part.

"**§ 131E-144.3. Declaration of home care clients' rights.**

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(1) To be informed and participate in his or her plan of care.

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(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.

(11) To be informed of supervisory accessibility and availability.

(12) To be advised of the agency's procedures for discharge.

(13) To receive a reasonable response to his or her requests of the agency.

(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

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(2) The address and telephone number for information, questions, or complaints about services provided by the agency.

(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"**§ 131E-144.5. Implementation.**

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"**§ 131E-144.6. Enforcement and investigation.**

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

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(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint.

"**§ 131E-144.7. Confidentiality.**

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 3. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 4. Section 2 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

SENATE BILL 42:
Home Care Changes

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	May 19, 2005
Introduced by:	Sen. Swindell	**Summary by:**	Shawn Parker Committee Staff
Version:	PCS to First Edition S42-CSSQ-14		

SUMMARY: Senate Bill 42 would amend the Home Care Agency Licensure Act, establish the Home Care Clients' Bill of Rights, and direct the Department of Health and Human Services to study whether any additional "health care facilities" or "health care personnel" should be defined in the Health Care Personnel Registry.

BILL ANALYSIS:

Section 1 of Senate Bill 42 amends G.S. 131E-140 to provide that the North Carolina Medical Care Commission:

- Adopt, amend, and repeal rules necessary for the implementation of the Home Care Clients' Bill of Rights contained in Section 2 of the bill.
- Adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.
- Adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

Section 2 of the bill establishes the Home Care Clients' Bill of Rights by adding Part 3A to the Home Care Agency Licensure Act. The North Carolina Administrative Code (NCAC) contains rules for The Licensing of Home Care Agencies. Clients Rights and Responsibilities are outlined in 10A NCAC 13J .1007. These rights are <u>not</u> currently codified in the North Carolina General Statutes.

- Section 2 of this bill, establishing the Home Care Clients' Bill of Rights, generally mirrors the structure of the Adult Care Home Residents' Bill of Rights (Chapter 131D, Article 3), and the Nursing Home Patients' Bill of Rights (Chapter 131E, Article 6, Part 2). The Adult Care Home Residents' Bill of Rights, the Nursing Home Patient's Bill of Rights, and the Home Care Clients' Bill of Rights all have the following sections in common: Legislative Intent, Definitions, Declaration of Rights, Notice, Enforcement and Investigation, and Confidentiality.
- The title of the Section 10A NCAC 13J .1007 is CLIENT RIGHTS AND RESPONSIBILITIES.
    - Subsection (a) of 10A NCAC 13J .1007 states that, "An agency must provide each client with a written notice of the client's rights and responsibilities in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services. The agency shall maintain documentation showing that all clients have been informed of their rights and responsibilities." This concept is reflected in new G.S. 131E-144.4.
    - Subsection (b) of 10A NCAC 13J .1007 begins, "Clients' rights shall include at a minimum clients' rights to..." The rest of the subsection contains nine (9) clients rights. Although the section heading incorporates the word "RESPONSIBILITIES", subsection (b) which lists the nine (9) clients' rights does <u>not</u> contain the word "responsibilities."

These rights are contained in new G.S. 131E-144.3. Consistent with the subsection of the rules, the subsection of the bill does not contain the word "responsibilities."

- Subsection (c) of Section .1007 requires an agency to provide clients with a telephone number for information, questions, or complaints; and requires the agency to provide the number for the Division of Facility Services complaint hotline. This subsection also specifies that DFS will investigate allegations of non-compliance with the rules. The provisions of this subsection are represented in new G.S. 131E-144.4 and G.S. 131E-144.6.
- Subsection (d) of Section .1007 requires an agency to investigate, within 72 hours, complaints made to the agency by a client or the client's family, an to document both the existence of the complaint and the resolution of the complaint. This provision is represented in new G.S. 131E-144.6(d).

- The Nursing Home Patients' Bill of Rights outlines 16 rights, the Adult Care Home Residents' Bill of Rights outlines 17 rights, and the NCAC currently outlines 9 home care client rights. This bill contains 14 rights. All nine (9) client rights that are contained in the NCAC are represented in the bill, although the wording may have been modified or expanded. Rights contained in subsections 2, 3, 6, 13, and 14 under new G.S. 131E-144.3 are not listed in the NCAC, but mirror the Bills of Rights for residents in adult care homes and patients in nursing homes.

Section 3 requires the Department to study whether there are any additional "health care facilities" (G.S. 131E-256(b)) and "health care personnel" (G.S. 131-256(c)) that should be listed in the definitions contained in the Health Care Personnel Registry (G.S. 131E-256). The bill requires the Department to report findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

EFFECTIVE DATE: Section 2 of the Senate Bill 42, which establishes the Home Care Clients' Bill of Rights, becomes effective January 1, 2006, and the remainder of the bill becomes effective when it becomes law.

BACKGROUND: Recommendations 3, 4, and 5 contained in the North Carolina Study Commission on Aging's report to the Governor and the 2005 Regular Session of the 2005 General Assembly are represented in the bill

S0042e1-SMSQ-CSSQ-14

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 268

Short Title:	Public Laws - 2.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Rules and Operations of the Senate.	

March 1, 2005

A BILL TO BE ENTITLED

AN ACT AMENDING THE PUBLIC LAWS OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. This act amends the public laws of North Carolina.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 268
PROPOSED COMMITTEE SUBSTITUTE S268-PCS65332-LN-47

Short Title: Animal Exhibition Sanitation/"Aedin's Law". (Public)

Sponsors:

Referred to:

March 1, 2005

A BILL TO BE ENTITLED

AN ACT TO ENACT "AEDIN'S LAW" TO DIRECT THE COMMISSIONER OF AGRICULTURE TO ADOPT RULES ESTABLISHING PERMITTING AND SANITATION REQUIREMENTS FOR ANIMAL EXHIBITIONS.

Whereas, contact with animals in public settings such as fairs, farm tours, and petting zoos provides opportunities for entertainment and education concerning animals and animal husbandry; and

Whereas, inadequate understanding of disease transmission can lead to infectious diseases among visitors, especially children, in these public settings; and

Whereas, in 2004, Aedin, a two-year-old child, and her family visited a petting zoo in North Carolina; and

Whereas, shortly after the visit to the petting zoo, Aedin contracted E. coli infection, was hospitalized for 36 days, and continues to suffer serious, lifelong complications from the infection and related Hemolytic Uremic Syndrome (HUS); and

Whereas, it is in the interest of the public health of this State to ensure that proper sanitation and other procedures are in place at fairs and animal exhibitions to address the potential for disease transmission; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) The title to Part 4 of Article 45 of Chapter 106 of the General Statutes reads as rewritten:

"Part 4. Supervision of ~~Fairs.~~Fairs and Animal Exhibitions."

SECTION 1.(b) Part 4 of Article 45 of Chapter 106 of the General Statutes is amended by adding the following new section to read:

"**§ 106-520.3A. Animal exhibition regulation; permit required; civil penalties.**

(a) Title. – This section may be referred to as "Aedin's Law". This section provides for the regulation of animal exhibitions as they may affect the public health and safety.

(b) Definitions. – As used in this section, unless the context clearly requires otherwise:

(1) 'Animal' means only those animals that may transmit infectious diseases.

(2) 'Animal exhibition' means any sanctioned agricultural fair where animals are displayed on the exhibition grounds for physical contact with humans.

(c) Permit Required. – No animal exhibition may be operated for use by the general public unless the owner or operator has obtained an operation permit issued by the Commissioner. The Commissioner may issue an operation permit only after physical inspection of the animal exhibition and a determination that the animal exhibition meets the requirements of this section and rules adopted pursuant to this section. The Commissioner may deny, suspend, or revoke a permit on the basis that the exhibition does not comply with this section or rules adopted pursuant to this section.

(d) Rules. – For the protection of the public health and safety, the Commissioner of Agriculture, with the advice and approval of the State Board of Agriculture, and in consultation with the Division of Public Health of the Department of Health and Human Services, shall adopt rules concerning the operation of and issuance of permits for animal exhibitions. The rules shall include requirements for:

(1) Education and signage to inform the public of health and safety issues.

(2) Animal areas.

(3) Animal care and management.

(4) Transition and nonanimal areas.

(5) Hand-washing facilities.

(6) Other requirements necessary for the protection of the public health and safety.

(e) Educational Outreach. – The Department shall continue its consultative and educational efforts to inform agricultural fair operators, exhibitors, agritourism business operators, and the general public about the health risks associated with diseases transmitted by physical contact with animals.

(f) Civil Penalty. – In addition to the denial, suspension, or revocation of an operation permit, the Commissioner may assess a civil penalty of not more than five thousand dollars ($5,000) against any person who violates a provision of this section or a rule adopted pursuant to this section. In determining the amount of the penalty, the Commissioner shall consider the degree and extent of harm caused by the violation.

The clear proceeds of civil penalties assessed pursuant to this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(g) Legal Representation by Attorney General. – It shall be the duty of the Attorney General to represent the Department of Agriculture and Consumer Services or designate a member of the Attorney General's staff to represent the Department in all actions or proceedings in connection with this section."

SECTION 2. This act becomes effective October 1, 2005. The Department of Agriculture shall use funds available for the 2005-2007 fiscal biennium to implement this act.

SENATE BILL 268:
Animal Exhibition Sanitation/"Aedin's Law"

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 31, 2005
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin
Version:	PCS to First Edition S268-PCS65332-LN-47		Committee Counsel

SUMMARY: Senate Bill 268, "Aedin's Law", would direct the Commissioner of Agriculture to adopt rules establishing sanitation and permitting requirements for animal exhibitions. The bill would amend Part 4 of Article 45 of Chapter 106 of the General Statutes by adding a new section to provide for regulation of animal exhibitions as they may affect the public health and safety.

BILL ANALYSIS: Senate Bill 268 would direct the Commissioner of Agriculture to adopt rules establishing sanitation and permitting requirements for animal exhibitions. The bill would amend Part 4 of Article 45 of Chapter 106 of the General Statutes by adding a new section to provide for regulation of animal exhibitions as they may affect the public health and safety.

The bill would require that the owner or operator of an animal exhibition obtain an operation permit in order to be allowed to operate an animal exhibition for use by the general public. The Commissioner would be authorized to deny, suspend, or revoke a permit on the basis that the exhibition does not comply with this section of the statutes or rules adopted pursuant to this section.

The bill would direct the Commissioner of Agriculture to adopt rules concerning the operation of and issuance of permits for animal exhibitions. These rules would be developed by the Commissioner, with the advice and approval of the State Board of Agriculture, and in consultation with the Division of Public Health of the Department of Health and Human Services. The rules would include requirements for the following:

1. Education and signage to inform the public of health and safety issues;
2. Animal areas;
3. Animal care and management;
4. Transition and nonanimal areas;
5. Hand-washing facilities; and
6. Other requirements necessary for the protection of the public health and safety.

The bill would direct the Department of Health and Human Services to conduct educational outreach to inform agricultural fair operators, exhibitors, agritourism business operators, and the general public about the health risks associated with diseases transmitted by physical contact with animals.

The bill would authorize the Commissioner to assess a civil penalty of not more than $5,000 for violation of provisions of the statutes or of the rules adopted pursuant to this section of the statutes. The Attorney General or a designated member of the Attorney General's staff would represent the Department in all actions or proceedings in connection with this section.

EFFECTIVE DATE: The bill would become effective October 1, 2005.

S0268e1-SMRD-PCS65332-LN-47

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 489

Short Title:	Cosmetic Art Definitions/Exam Facilities.	(Public)
Sponsors:	Senators Cowell, Kerr; and Snow.	
Referred to:	Health Care.	

March 15, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS TO CLARIFY CERTAIN DEFINITIONS UNDER THE NORTH CAROLINA COSMETIC ART ACT, TO APPROVE EXAMINATION FACILITIES, AND TO SET LIMITS FOR FAILED CANDIDATES SEEKING TO RETAKE AN EXAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88B-2 reads as rewritten:

"**§ 88B-2. Definitions.**

The following definitions apply in this Chapter:

(1) Apprentice. – A person who is not a manager or operator and who is engaged in learning the practice of cosmetic art under the direction and supervision of a cosmetologist.

(2) Board. – The North Carolina Board of Cosmetic Art Examiners.

(3) Booth. – A workstation located within a licensed cosmetic art shop that is operated primarily by one individual in performing cosmetic art services for consumers.

(4) Booth renter. – A person who rents a booth in a cosmetic art shop.

(5) Cosmetic art. – All or any part or combination ~~of: (i) the systematic massaging with the hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, and marcelling the hair, and the use of electricity for stimulating growth of hair.~~of cosmetology, esthetics, or manicuring.

(6) Cosmetic art school. – Any building or part thereof where cosmetic art is taught.

(7) Cosmetic art shop. – Any building or part thereof where cosmetic art is practiced for pay or reward, whether direct or indirect.

(8) Cosmetologist. – Any individual who is licensed to practice all parts of cosmetic art.

(8a) Cosmetology. – The act of arranging, dressing, curling, waving, cleansing, cutting, singeing, bleaching, coloring, or similar work upon the hair of a person by any means, including the use of hands, mechanical or electrical apparatus, or appliances or by use of cosmetic or chemical preparations or antiseptics.

(9) Cosmetology teacher. – An individual licensed by the Board to teach all parts of cosmetic art.

(10) Esthetician. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes skin care.

(11) Esthetician teacher. – An individual licensed by the Board to teach only that part of cosmetic art that constitutes skin care.

(11a) Esthetics. – Refers to any of the following practices: giving facials; applying makeup; performing skin care; removing superfluous hair from the body of a person by use of depilatories, tweezers, or waxing; applying eyelashes to a person, including the application of brow or lash color; beautifying the face, neck, arms, or upper part of the human body by use of cosmetic preparations, antiseptics, tonics, lotions, or creams; surface massaging in relation to skin care; or cleaning or stimulating the face, neck, ears, arms, hands, bust, torso, legs, or feet of a person by means of hands, devices, apparatus, or appliances along with the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

(12) Manicuring. – The care and treatment of the fingernails, toenails, cuticles on fingernails and toenails, and the hands and feet, including the decoration of the fingernails and the application of nail extensions and artificial nails. The term "manicuring" shall not include the treatment of pathologic conditions.

(13) Manicurist. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes manicuring.

(14) Manicurist teacher. – An individual licensed by the Board to teach manicuring.

(15) Shampooing. – The application and removal of commonly used, room temperature, liquid hair cleaning and hair conditioning products. Shampooing does not include the arranging, dressing, waving, coloring, or other treatment of the hair."

SECTION 2. G.S. 88B-18 reads as rewritten:

"**§ 88B-18. Examinations.**

(a) Each applicant for any examination shall file an application with the Board, on a form approved by the Board, which shall be verified by the applicant under oath,

and the applicant shall pay the required examination fee. Applications shall be filed at least 30 days before the requested examination date.

(b) Each examination shall have both a practical and a written portion.

(c) Examinations for applicants for apprentice, cosmetologist, teacher, esthetician, and manicurist licenses shall be given in at least three locations in the State that are geographically scattered. The examinations shall be administered in ~~the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. The Board shall reimburse an institution, if requested, for the use of its facilities in administering examinations.~~Board-approved facilities.

(d) An applicant for a ~~cosmetologist~~ cosmetologist, esthetician, manicurist, or teacher's license who fails to pass the examination three times may not reapply to take the examination again until after the applicant has successfully completed any additional requirements prescribed by the Board."

SECTION 3. G.S. 88B-9 reads as rewritten:

"**§ 88B-9. Qualifications for licensing as an esthetician.**

The Board shall issue a license to practice as an esthetician to any individual who meets all of the following requirements:

(1) Successful completion of at least 600 hours of an ~~esthetician~~ esthetics curriculum in an approved cosmetic art school.

(2) Passage of an examination conducted by the Board.

(3) Payment of the fees required by G.S. 88B-20."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 489
PROPOSED HOUSE COMMITTEE SUBSTITUTE S489-CSSQ-20 [v.3]

5/31/2005 2:19:15 PM

Short Title: Cosmetic Art Definitions/Exam Facilities. (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT ADDING A MEMBER TO THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS, AUTHORIZING THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS TO CLARIFY CERTAIN DEFINITIONS UNDER THE NORTH CAROLINA COSMETIC ART ACT, TO APPROVE EXAMINATION FACILITIES, AND TO SET LIMITS FOR FAILED CANDIDATES SEEKING TO RETAKE AN EXAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88B-3 reads as rewritten:

"**§ 88B-3. Creation and membership of the Board; term of office; removal for cause; officers.**

(a) The North Carolina Board of Cosmetic Art Examiners is established. The Board shall consist of ~~six~~seven members who shall be appointed as follows:

(1) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint a cosmetologist.

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint a cosmetologist.

(3) The Governor shall appoint two cosmetologists, a~~t~~wo cosmetology ~~teacher,~~teachers, and a member of the public who is not licensed under this Chapter.

(b) Each cosmetologist member shall have practiced all parts of cosmetic art in this State for at least five years immediately preceding appointment to the Board and shall not have any connection with any cosmetic art school while serving on the Board. ~~The~~One of the cosmetology teacher ~~member~~members shall be currently employed as a teacher by a North Carolina ~~public school, community college, or other public or~~ private cosmetic art school and shall have practiced or taught cosmetic art for at least five years immediately preceding appointment to the Board. The other cosmetology teacher member shall be currently employed as a teacher by a North Carolina community

college and shall have practiced or taught cosmetic art for at least five years at a North Carolina community college immediately preceeding appointment to the Board.

(c) Cosmetologist members of the Board shall serve staggered terms of three years. No Board member shall serve more than two consecutive terms, except that each member shall serve until a successor is appointed and qualified. All other board members shall serve three-year terms, but they shall not be staggered.

(d) The Governor may remove any member of the Board for cause.

(e) A vacancy shall be filled in the same manner as the original appointment, except that unexpired terms in seats appointed by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(f) The Board shall elect a chair, a vice-chair, and other officers as deemed necessary by the Board to carry out the purposes of this Chapter. All officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(g) The Board shall not issue a teacher's license to any Board member during that member's term on the Board.

(h) No Board member may be employed by the Board for at least one year after that member's term expires."

SECTION 2. G.S. 88B-2 reads as rewritten:

"§ 88B-2. Definitions.

The following definitions apply in this Chapter:

(1) Apprentice. – A person who is not a manager or operator and who is engaged in learning the practice of cosmetic art under the direction and supervision of a cosmetologist.

(2) Board. – The North Carolina Board of Cosmetic Art Examiners.

(3) Booth. – A workstation located within a licensed cosmetic art shop that is operated primarily by one individual in performing cosmetic art services for consumers.

(4) Booth renter. – A person who rents a booth in a cosmetic art shop.

(5) Cosmetic art. – All or any part or combination ~~of: (i) the systematic massaging with the hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, and marcelling the hair, and the use of electricity for stimulating growth of hair.~~of cosmetology, esthetics, or manicuring.

(6) Cosmetic art school. – Any building or part thereof where cosmetic art is taught.

(7) Cosmetic art shop. – Any building or part thereof where cosmetic art is practiced for pay or reward, whether direct or indirect.

(8) Cosmetologist. – Any individual who is licensed to practice all parts of cosmetic art.

(8a) Cosmetology. – The act of arranging, dressing, curling, waving, cleansing, cutting, singeing, bleaching, coloring, or similar work upon the hair of a person by any means, including the use of hands, mechanical or electrical apparatus, or appliances or by use of cosmetic or chemical preparations or antiseptics.

(9) Cosmetology teacher. – An individual licensed by the Board to teach all parts of cosmetic art.

(10) Esthetician. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes skin care.

(11) Esthetician teacher. – An individual licensed by the Board to teach only that part of cosmetic art that constitutes skin care.

(11a) Esthetics. – Refers to any of the following practices: giving facials; applying makeup; performing skin care; removing superfluous hair from the body of a person by use of creams, tweezers, or waxing; applying eyelashes to a person, including the application of brow or lash color; beautifying the face, neck, arms, or upper part of the human body by use of cosmetic preparations, antiseptics, tonics, lotions, or creams; surface massaging in relation to skin care; or cleaning or stimulating the face, neck, ears, arms, hands, bust, torso, legs, or feet of a person by means of hands, devices, apparatus, or appliances along with the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

(12) Manicuring. – The care and treatment of the fingernails, toenails, cuticles on fingernails and toenails, and the hands and feet, including the decoration of the fingernails and the application of nail extensions and artificial nails. The term "manicuring" shall not include the treatment of pathologic conditions.

(13) Manicurist. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes manicuring.

(14) Manicurist teacher. – An individual licensed by the Board to teach manicuring.

(15) Shampooing. – The application and removal of commonly used, room temperature, liquid hair cleaning and hair conditioning products. Shampooing does not include the arranging, dressing, waving, coloring, or other treatment of the hair."

SECTION 3. G.S. 88B-18 reads as rewritten:

"§ 88B-18. Examinations.

(a) Each applicant for any examination shall file an application with the Board, on a form approved by the Board, which shall be verified by the applicant under oath, and the applicant shall pay the required examination fee. Applications shall be filed at least 30 days before the requested examination date.

(b) Each examination shall have both a practical and a written portion.

(c) Examinations for applicants for apprentice, cosmetologist, teacher, esthetician, and manicurist licenses shall be given in at least three locations in the State

that are geographically scattered. The examinations shall be administered in ~~the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. The Board shall reimburse an institution, if requested, for the use of its facilities in administering examinations.~~Board-approved facilities.

(d) An applicant for a ~~cosmetologist~~ cosmetologist, esthetician, manicurist, or teacher's license who fails to pass the examination three times may not reapply to take the examination again until after the applicant has successfully completed any additional requirements prescribed by the Board."

SECTION 4. G.S. 88B-9 reads as rewritten:

"**§ 88B-9. Qualifications for licensing as an esthetician.**

The Board shall issue a license to practice as an esthetician to any individual who meets all of the following requirements:

(1) Successful completion of at least 600 hours of an ~~esthetician~~ esthetics curriculum in an approved cosmetic art school.

(2) Passage of an examination conducted by the Board.

(3) Payment of the fees required by G.S. 88B-20."

SECTION 5. This act is effective when it becomes law.

SENATE BILL 489:
Cosmetic Art Definitions/Exam Provisions

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senators Cowell and Kerr
Date:	May 24, 2005	**Summary by:**	Shawn Parker
Version:	PCS to 1st edition		Committee Staff

SUMMARY: Senate Bill 489 amends the Cosmetic Art Act as follows:

- *Clarifies the definition of Cosmetic Art.*
- *Provides definitions for the terms "Cosmetology" and "Esthetics"*
- *Expands certain examination provisions of the act to include manicurists, estheticians, and cosmetology teachers.*

The proposed committee substitute eliminates the provision in the original bill that authorized the North Carolina Board of Cosmetic Art Examiners to approve facilities for licensure examination.

CURRENT LAW: The practice of cosmetic art is regulated by a Board of Cosmetic Art Examiners. Cosmetic art is defined as all or any part or combination of: (i) the systemic massaging with hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, marcelling the hair, and the use of electricity for stimulating growth of hair. The terms cosmetology and esthetics are not defined.

Current law provides that cosmetology examinations must be administered in the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. If a cosmetology applicant fails the licensure examination three times, the applicant may not reapply to take the examination until the applicant successfully completes additional requirements.

BILL ANALYSIS: Senate Bill 489 would define cosmetic art as cosmetology, esthetics, or manicuring and would define cosmetology and esthetics as follows:

- "Cosmetology" would generally mean acts relating to hair cutting, coloring, or styling.
- "Esthetics" would generally mean acts relating to skin care and makeup, including waxing.

Senate Bill 489 also expands the examination provision regarding reapplying for examination of the act to include manicurists, estheticians, and cosmetology teachers.

The act is effective when it becomes law.

S489-SMSQ-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1020

Short Title:	Restaurants/Provide Info on Use of Peanuts.	(Public)
Sponsors:	Senators Graham; and Cowell.	
Referred to:	Health Care.	

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSION FOR HEALTH SERVICES TO ADOPT RULES REQUIRING FOOD ESTABLISHMENTS TO POST INFORMATION ABOUT CERTAIN FOOD ALLERGIES.

Whereas, research estimates that one in every 200 people may be allergic to nuts and nut products, and one in 100 may be allergic without ever having had an allergic reaction; and

Whereas, anyone can develop nut allergies, but the allergy is more common in people who have other conditions such as eczema or hay fever, or other inherited allergic conditions; and

Whereas, the majority of children and 50% of adults who are allergic to peanuts are allergic to other types of nuts; and

Whereas, exposure to nut products can cause anaphylaxis in persons with severe allergies; and

Whereas, there is no cure for nut allergies, and thus the best way to avoid an allergic reaction is to avoid consumption of nut products; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding the following new subsection to read:

"(c2) The Commission shall adopt rules requiring establishments that prepare or serve food containing nut products to post a consumer advisory in a conspicuous place where it may be readily observed by the public prior to consumption of the food. The advisory shall explain nut allergies and health-related consequences to individuals with nut allergies who are exposed to food items that contain or are prepared with nut products. In addition to the consumer advisory, the establishment shall include in or with its menu an advisory statement about nut allergies. As used in this subsection, "nut" means peanuts and tree nuts, including almonds, brazil nuts, cashews, hazelnuts, filberts, macadamia nuts, pecans, pistachios, walnuts, and any other nut products that, when consumed, may produce an allergic reaction in persons with nut allergies."

SECTION 2. The Department of Health and Human Services, Division of Public Health, shall prepare a fact sheet designed to explain nut allergies and the health-related consequences of the consumption of nut products by individuals with nut allergies. The Department shall make the fact sheet available to local boards of health, and local health inspectors shall furnish this information to establishments subject to G.S. 130A-248(c2) at the time of inspection.

SECTION 3. This act becomes effective October 1, 2005. The Department of Health and Human Services, Division of Public Health, may adopt temporary rules to implement this act.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 01, 2005

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

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

S.B. **42** Home Care Changes.

Draft Number:	PCS 55250
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **489** Cosmetic Art Definitions/Exam Facilities.

Draft Number:	PCS 15251
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 489
PROPOSED HOUSE COMMITTEE SUBSTITUTE S489-PCS15251-SQ-20

Short Title: Cosmetic Art Definitions/Exam Facilities. (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT ADDING A MEMBER TO THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS, AUTHORIZING THE NORTH CAROLINA BOARD OF COSMETIC ART EXAMINERS TO CLARIFY CERTAIN DEFINITIONS UNDER THE NORTH CAROLINA COSMETIC ART ACT, TO APPROVE EXAMINATION FACILITIES, AND TO SET LIMITS FOR FAILED CANDIDATES SEEKING TO RETAKE AN EXAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88B-3 reads as rewritten:

"**§ 88B-3. Creation and membership of the Board; term of office; removal for cause; officers.**

(a) The North Carolina Board of Cosmetic Art Examiners is established. The Board shall consist of ~~six~~seven members who shall be appointed as follows:

(1) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint a cosmetologist.

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint a cosmetologist.

(3) The Governor shall appoint two cosmetologists, atwo cosmetology ~~teacher,~~teachers, and a member of the public who is not licensed under this Chapter.

(b) Each cosmetologist member shall have practiced all parts of cosmetic art in this State for at least five years immediately preceding appointment to the Board and shall not have any connection with any cosmetic art school while serving on the Board. ~~The~~One of the cosmetology teacher ~~member~~members shall be currently employed as a teacher by a North Carolina ~~public school, community college, or other public or~~ private cosmetic art school and shall have practiced or taught cosmetic art for at least five years immediately preceding appointment to the Board. The other cosmetology teacher member shall be currently employed as a teacher by a North Carolina community

college and shall have practiced or taught cosmetic art for at least five years at a North Carolina community college immediately preceding appointment to the Board.

(c) Cosmetologist members of the Board shall serve staggered terms of three years. No Board member shall serve more than two consecutive terms, except that each member shall serve until a successor is appointed and qualified. All other board members shall serve three-year terms, but they shall not be staggered.

(d) The Governor may remove any member of the Board for cause.

(e) A vacancy shall be filled in the same manner as the original appointment, except that unexpired terms in seats appointed by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(f) The Board shall elect a chair, a vice-chair, and other officers as deemed necessary by the Board to carry out the purposes of this Chapter. All officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(g) The Board shall not issue a teacher's license to any Board member during that member's term on the Board.

(h) No Board member may be employed by the Board for at least one year after that member's term expires."

SECTION 2. G.S. 88B-2 reads as rewritten:

"**§ 88B-2. Definitions.**

The following definitions apply in this Chapter:

(1) Apprentice. – A person who is not a manager or operator and who is engaged in learning the practice of cosmetic art under the direction and supervision of a cosmetologist.

(2) Board. – The North Carolina Board of Cosmetic Art Examiners.

(3) Booth. – A workstation located within a licensed cosmetic art shop that is operated primarily by one individual in performing cosmetic art services for consumers.

(4) Booth renter. – A person who rents a booth in a cosmetic art shop.

(5) Cosmetic art. – All or any part or combination ~~of: (i) the systematic massaging with the hands or mechanical apparatus of the scalp, face, neck, shoulders, hands, and feet; (ii) the use of cosmetic chemicals and preparations and antiseptics; (iii) manicuring, including the application of artificial nails; (iv) esthetics; or (v) cutting, coloring, cleansing, arranging, dressing, waving, and marcelling the hair, and the use of electricity for stimulating growth of hair.~~of cosmetology, esthetics, or manicuring.

(6) Cosmetic art school. – Any building or part thereof where cosmetic art is taught.

(7) Cosmetic art shop. – Any building or part thereof where cosmetic art is practiced for pay or reward, whether direct or indirect.

(8) Cosmetologist. – Any individual who is licensed to practice all parts of cosmetic art.

(8a) Cosmetology. – The act of arranging, dressing, curling, waving, cleansing, cutting, singeing, bleaching, coloring, or similar work upon the hair of a person by any means, including the use of hands, mechanical or electrical apparatus, or appliances or by use of cosmetic or chemical preparations or antiseptics.

(9) Cosmetology teacher. – An individual licensed by the Board to teach all parts of cosmetic art.

(10) Esthetician. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes skin care.

(11) Esthetician teacher. – An individual licensed by the Board to teach only that part of cosmetic art that constitutes skin care.

(11a) Esthetics. – Refers to any of the following practices: giving facials; applying makeup; performing skin care; removing superfluous hair from the body of a person by use of creams, tweezers, or waxing; applying eyelashes to a person, including the application of brow or lash color; beautifying the face, neck, arms, or upper part of the human body by use of cosmetic preparations, antiseptics, tonics, lotions, or creams; surface massaging in relation to skin care; or cleaning or stimulating the face, neck, ears, arms, hands, bust, torso, legs, or feet of a person by means of hands, devices, apparatus, or appliances along with the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

(12) Manicuring. – The care and treatment of the fingernails, toenails, cuticles on fingernails and toenails, and the hands and feet, including the decoration of the fingernails and the application of nail extensions and artificial nails. The term "manicuring" shall not include the treatment of pathologic conditions.

(13) Manicurist. – An individual licensed by the Board to practice only that part of cosmetic art that constitutes manicuring.

(14) Manicurist teacher. – An individual licensed by the Board to teach manicuring.

(15) Shampooing. – The application and removal of commonly used, room temperature, liquid hair cleaning and hair conditioning products. Shampooing does not include the arranging, dressing, waving, coloring, or other treatment of the hair."

SECTION 3. G.S. 88B-18 reads as rewritten:

"**§ 88B-18. Examinations.**

(a) Each applicant for any examination shall file an application with the Board, on a form approved by the Board, which shall be verified by the applicant under oath, and the applicant shall pay the required examination fee. Applications shall be filed at least 30 days before the requested examination date.

(b) Each examination shall have both a practical and a written portion.

(c) Examinations for applicants for apprentice, cosmetologist, teacher, esthetician, and manicurist licenses shall be given in at least three locations in the State

that are geographically scattered. The examinations shall be administered in ~~the Board's office or in a publicly supported two-year postsecondary educational institution with appropriate facilities. The Board shall reimburse an institution, if requested, for the use of its facilities in administering examinations.~~Board-approved facilities.

(d) An applicant for a ~~cosmetologist~~ cosmetologist, esthetician, manicurist, or teacher's license who fails to pass the examination three times may not reapply to take the examination again until after the applicant has successfully completed any additional requirements prescribed by the Board."

SECTION 4. G.S. 88B-9 reads as rewritten:

"**§ 88B-9. Qualifications for licensing as an esthetician.**

The Board shall issue a license to practice as an esthetician to any individual who meets all of the following requirements:

(1) Successful completion of at least 600 hours of an ~~esthetician~~ esthetics curriculum in an approved cosmetic art school.

(2) Passage of an examination conducted by the Board.

(3) Payment of the fees required by G.S. 88B-20."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 42*
PROPOSED COMMITTEE SUBSTITUTE S42-PCS55250-SQ-14

Short Title: Home Care Changes. (Public)

Sponsors:

Referred to:

February 3, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT AND TO ESTABLISH HOME CARE CLIENTS' RIGHTS AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"**§ 131E-140. Rules and enforcement.**

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(a3) The Commission shall adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§ 131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§ 131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part.

"**§ 131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.

(11) To be informed of supervisory accessibility and availability.

(12) To be advised of the agency's procedures for discharge.

(13) To receive a reasonable response to his or her requests of the agency.

(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"**§ 131E-144.4. Notice to client.**

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

(1) A copy of the declaration of home care clients' rights.

(2) The address and telephone number for information, questions, or complaints about services provided by the agency.

(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"**§ 131E-144.5. Implementation.**

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"**§ 131E-144.6. Enforcement and investigation.**

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint.

"**§ 131E-144.7. Confidentiality.**

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 3. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 4. Section 2 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 268
PROPOSED COMMITTEE SUBSTITUTE S268-PCS65332-LN-47

Short Title: Animal Exhibition Sanitation/"Aedin's Law". (Public)

Sponsors:

Referred to:

March 1, 2005

A BILL TO BE ENTITLED

AN ACT TO ENACT "AEDIN'S LAW" TO DIRECT THE COMMISSIONER OF AGRICULTURE TO ADOPT RULES ESTABLISHING PERMITTING AND SANITATION REQUIREMENTS FOR ANIMAL EXHIBITIONS.

Whereas, contact with animals in public settings such as fairs, farm tours, and petting zoos provides opportunities for entertainment and education concerning animals and animal husbandry; and

Whereas, inadequate understanding of disease transmission can lead to infectious diseases among visitors, especially children, in these public settings; and

Whereas, in 2004, Aedin, a two-year-old child, and her family visited a petting zoo in North Carolina; and

Whereas, shortly after the visit to the petting zoo, Aedin contracted E. coli infection, was hospitalized for 36 days, and continues to suffer serious, lifelong complications from the infection and related Hemolytic Uremic Syndrome (HUS); and

Whereas, it is in the interest of the public health of this State to ensure that proper sanitation and other procedures are in place at fairs and animal exhibitions to address the potential for disease transmission; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) The title to Part 4 of Article 45 of Chapter 106 of the General Statutes reads as rewritten:

"Part 4. Supervision of ~~Fairs.~~Fairs and Animal Exhibitions."

SECTION 1.(b) Part 4 of Article 45 of Chapter 106 of the General Statutes is amended by adding the following new section to read:

"**§ 106-520.3A. Animal exhibition regulation; permit required; civil penalties.**

(a) Title. – This section may be referred to as "Aedin's Law". This section provides for the regulation of animal exhibitions as they may affect the public health and safety.

(b) Definitions. – As used in this section, unless the context clearly requires otherwise:

(1) 'Animal' means only those animals that may transmit infectious diseases.

(2) 'Animal exhibition' means any sanctioned agricultural fair where animals are displayed on the exhibition grounds for physical contact with humans.

(c) Permit Required. – No animal exhibition may be operated for use by the general public unless the owner or operator has obtained an operation permit issued by the Commissioner. The Commissioner may issue an operation permit only after physical inspection of the animal exhibition and a determination that the animal exhibition meets the requirements of this section and rules adopted pursuant to this section. The Commissioner may deny, suspend, or revoke a permit on the basis that the exhibition does not comply with this section or rules adopted pursuant to this section.

(d) Rules. – For the protection of the public health and safety, the Commissioner of Agriculture, with the advice and approval of the State Board of Agriculture, and in consultation with the Division of Public Health of the Department of Health and Human Services, shall adopt rules concerning the operation of and issuance of permits for animal exhibitions. The rules shall include requirements for:

(1) Education and signage to inform the public of health and safety issues.

(2) Animal areas.

(3) Animal care and management.

(4) Transition and nonanimal areas.

(5) Hand-washing facilities.

(6) Other requirements necessary for the protection of the public health and safety.

(e) Educational Outreach. – The Department shall continue its consultative and educational efforts to inform agricultural fair operators, exhibitors, agritourism business operators, and the general public about the health risks associated with diseases transmitted by physical contact with animals.

(f) Civil Penalty. – In addition to the denial, suspension, or revocation of an operation permit, the Commissioner may assess a civil penalty of not more than five thousand dollars ($5,000) against any person who violates a provision of this section or a rule adopted pursuant to this section. In determining the amount of the penalty, the Commissioner shall consider the degree and extent of harm caused by the violation.

The clear proceeds of civil penalties assessed pursuant to this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(g) Legal Representation by Attorney General. – It shall be the duty of the Attorney General to represent the Department of Agriculture and Consumer Services or designate a member of the Attorney General's staff to represent the Department in all actions or proceedings in connection with this section."

SECTION 2. This act becomes effective October 1, 2005. The Department of Agriculture shall use funds available for the 2005-2007 fiscal biennium to implement this act.

VISITOR REGISTRATION SHEET

Senate Health Care — **June 1, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Keith E. Moore	Luvsen Corp.
Mike Lancaster	Doc of Day CH, NC
Elizabeth Wickham	
Doug Van Essen	NC State Board of Cosmetic Art
Ray Mitchell	"
John Cyrus	NCSG
John Bowdish	AstraZeneca
Brian Shank	AstraZeneca
Andy Ellen	NCRMA
[illegible]	NCCCS
Laura Garland	WakeMed

VISITOR REGISTRATION SHEET

Senate Health Care — **June 1, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christine Craig	WakeMed
[signature]	Poyner & Spruill
DAVID BARNES	Poyner + Spruill
Dana Simpson	Smith Anderson
Danny Merlin	Smith Anderson
[signature]	Smith Anderson
[signature]	NCMS
[signature]	Capitol Group
[signature]	Capitol Group
[signature]	NCRA

AGENDA

SENATE HEALTH CARE COMMITTEE
May 11, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

• HB 613, Update Certification/Licensure/Red. Therapy	Rep. Harrell, III Rep. Womble
• HB 874, Title Change/Safety and Health Review Board	Rep. Goodwin
• HB 1357, Amend Acupuncture Laws/Fees	Rep. Gibson, III Rep. Fisher
• SB 673, Jobs for All Act	Sen. Nesbitt, Jr.

III. Other Business

IV. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, June 15, 2005

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

FAVORABLE

H.B.(CS #1) **874** Title Change/Safety and Health Review Board.
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) **1357** Amend Acupuncture Laws/Fees.
Draft Number: PCS70519
Sequential Referral: Finance
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, June 15, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 15, 2005, in Room 544 of the Legislative Office Building, with fourteen members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. Senator Purcell announced that SB 673, *Jobs for All Act*, would not be heard at this meeting.

Senator Purcell recognized Rep. Goodwin to explain HB 874, *Title Change/Safety and Health Review Board.* Senator Forrester asked who this Board would report to. Rep. Goodwin responded that it would report to the Department of Labor. Senator Dorsett moved for a favorable report, and the bill passed.

Rep. Harrell presented his bill, HB 613, *Update Certification/Licensure/Rec. Therapy*. Senator Jacumin asked if the fee structure in the bill meant that the fees are going up, and the response was that they are not.. Senator Bingham asked the differences among physical, occupational, and recreational therapies. Rep. Harrell called on Becky Garrett, executive director of the N.C. Therapeutic Recreation Certification Board, who asked Pamela Wilson, of the same Board to speak. She explained the differences, pointed out that the three are often used in tandem, and also explained the training required for these therapies. Senator Dannelly asked about a potential increase in fees. Ms. Garrett said that there is no expectation to increase fees. Senator Dorsett reiterated Sen. Dannelly's concern about a fee increase. Senator Forrester asked if the proposed board had been through the new licensing board procedure. Ms. Garrett responded that this is an update, not a new board. Senator Forrester pointed out that this bill states that this is a new board. He asked if insurance pays for these therapies and Ms. Garrett responded that these fees usually are incorporated in service fees. Senator Purcell asked Senator Rand if this bill should go through the Licensing Board, and he said that it should if it is a new board. Rep. Harrell said that this is a current structure, that the name is being changed from a certification board to a licensing board. After some discussion and consultation with Research staff, Senator Purcell recommended that a vote on this bill be delayed until determination is made as to the need for the bill to be referred to the Licensing Board.

Rep. Fisher brought her bill, HB 1357, *Amend Acupuncture Laws/Fees* to the committee. She said that this bill clarifies the statute, makes adjustments for the past ten years, amends licensing qualifications, and establishes a ceiling for fees. Senator Rand questioned the non-specificity of the term "agency" in the bill, as applies to standards and qualifications. Rep. Fisher called on Barbara Barry, chair of the NC Acupuncture Licensing Board, who pointed out that qualifications are very similar from state to state and that applicants for licensing must pass the national certification licensing exam, used by over 90 percent of the states. Senator Rand asked for an amendment to specify "agencies". Senators Goodall and Malone questioned various fees, and Ms. Barry responded. Senator Forrester asked if the bill increases the scope of practice, and the answer was "no". Marc Cutler, president of the NC Acupuncture Association spoke briefly in support of the bill. Senator Nesbitt moved for a favorable report for the bill, as amended. The bill passed as amended and was referred to Finance.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 613

Committee Substitute Favorable 5/18/05

Short Title: Update Certification/Licensure/Rec. Therapy. (Public)

Sponsors:

Referred to:

March 14, 2005

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS REGULATING THE PRACTICE OF RECREATIONAL THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90C-1 through G.S. 90C-19 are repealed.

SECTION 1.1. The title of Chapter 90C reads as rewritten:

"**Chapter 90C.**

~~**Therapeutic Recreation Personnel Certification Act.**~~ **North Carolina Recreational Therapy Licensure Act.**"

SECTION 2. Chapter 90C of the General Statutes is amended by adding the following new sections to read:

"**§ 90C-20. Short title.**

This Chapter shall be known as the 'North Carolina Recreational Therapy Licensure Act'.

"**§ 90C-21. Purpose.**

It is the purpose and intent of the Recreational Therapy Licensure Act to safeguard the health and safety of the public and to protect the public from harm by unqualified persons by establishing a minimum level of education, experience, and competence to assure the highest degree of professional care and conduct on the part of licensed recreational therapists and licensed recreational therapy assistants.

"**§ 90C-22. Definitions.**

In this Chapter, unless the context otherwise requires, the following definitions shall apply:

(1) Board. – The North Carolina Board of Recreational Therapy Licensure.

(2) Licensed recreational therapist. – A person who holds a license pursuant to this Chapter as a recreational therapist. A person licensed as a 'Recreational Therapist' under this Chapter may practice in clinical, residential, educational, and community settings and may:

a. Conduct an individualized patient or client assessment for the purpose of collecting systematic, comprehensive, and accurate data necessary to determine a course of action and subsequent individualized treatment plan.
b. Plan and develop the individualized treatment plan that identifies a patient or client's goals, objectives, and treatment intervention strategies.
c. Implement the individualized treatment plan that is consistent with the overall patient or client treatment program.
d. Systematically evaluate and compare the patient or client's response to the individualized treatment plan and suggest modifications as appropriate.
e. Develop a discharge plan in collaboration with the patient or client, his or her family, and other treatment team members.
f. Serve as a resource for patient or client recreation opportunities to promote or improve his or her general health and well-being..
g. Deliver services in accordance with the professional standards of practice and codes of ethics promulgated by national or State professional organizations.
h. Manage delivery of services in accordance with a written plan of operation based upon standards advanced by appropriate membership, regulatory, and credentialing agencies.
i. Provide professional and preprofessional education and training of recreational therapists or recreational therapy assistants.
j. Conduct research in the field of recreational therapy or therapeutic recreation.

(3) Licensed recreational therapy assistant. – A person who holds a license pursuant to this Chapter as a recreational therapy assistant to act under the supervision of a licensed recreational therapist as defined by rule. A person licensed as a 'Recreational Therapy Assistant' under this Chapter may assist in the practice of recreational therapy in clinical, residential, and community settings under the supervision of a licensed recreational therapist and in accordance with a recreational therapy assistant's training, education, and scope of practice, as defined by rule.

(4) Person. – Any individual, corporation, partnership, association, unit of government, or other legal entity.

(5) Recreational therapy aide. – Any nonlicensed person who aids in the provision of recreational therapy services under the provisions of this Chapter, and who, acts under the direction and on-site supervision of a licensed recreational therapist or licensed recreational therapy assistant. A recreational therapy aide may perform recreational therapy related duties and functions which are assigned and are commensurate with an aide's training and competency. An aide's work shall not

include responding to a physician's orders; designing, conducting, or interpreting individualized recreational therapy patient assessment; determining or modifying recreational therapy treatment plans or interventions; or any independent practice or performance of recreational therapy services.

(6) Scope of recreational therapy. – The practice of recreational therapy includes all direct patient or client services of assessment, planning, design, implementation, evaluation, and documentation of specific interventions, management, consultation, research, and education for either individuals or groups that require specific therapeutic recreation or recreational therapy intervention representing the process and knowledge base delineated in the most recent National Council for Therapeutic Recreation Certification (NCTRC) Job Analysis Study and professional standards of practice. Scope is inclusive of professional and preprofessional education and training in recreational therapy, therapeutic recreation, and related research.

(7) Recreational therapy. – A treatment service designed to restore, remediate, or rehabilitate a patient or client's level of functioning and independence in life activities, as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

(8) Therapeutic recreation. – The provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purposes of treatment services, which are often referred to as recreational therapy, are to restore, remediate, or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purposes of recreation services are to provide recreation resources and opportunities in order to improve health and well-being. Therapeutic recreation is provided by professionals who are trained and certified, registered, or licensed to provided therapeutic recreation.

"**§ 90C-23. North Carolina Recreational Therapy Licensure Board is created.**

(a) The North Carolina Recreational Therapy Licensure Board is created.

(b) Composition. – The Board shall consist of eight members appointed as follows:

(1) Three practicing recreational therapists, one of whom shall be appointed by the Governor, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore, and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

(2) One licensed practicing recreational therapy assistant appointed by the Governor.

(3) One licensed practicing recreational therapist who is engaged primarily in providing education or training for recreational therapists or recreational therapy assistants appointed by the Governor.

(4) One physician licensed pursuant to Article 1 of Chapter 90 of the General Statutes appointed by the Governor.

(5) Two public members, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

The Governor shall make appointments after consultation with the North Carolina Recreational Therapy Licensure Board and other interested persons.

(c) Qualifications. – The nonpublic recreational therapist or recreational therapy assistant members of the Board shall hold a current license. Each nonpublic recreational therapist or recreational therapy assistant member of the Board, at the time of his or her appointment and for at least two years before, shall have been actively engaged in North Carolina in the practice of recreational therapy or therapeutic recreation, in the education and training of graduate or undergraduate students of recreational therapy or therapeutic recreation, or in recreational therapy or therapeutic recreation research.

One public member shall not be a licensed health care professional or an agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. One public member shall have received recreational therapy or therapeutic recreation services. For purposes of this subsection, a person enrolled in a program to prepare him or her to be a licensed health care professional or an allied health professional shall not be eligible to serve as a public member of the Board. The spouse of any person who would be prohibited by this subsection from serving on the Board as a public member shall not serve as a public member of the Board. Public members shall reasonably reflect the population of this State.

(d) Term. – Members of the Board shall serve three-year staggered terms and shall serve until a successor is appointed and qualified. No member shall serve more than two consecutive full terms.

(e) Vacancies. – The Governor shall fill vacancies to the Board positions for which the Governor is the appointing authority within 30 days after a position is vacated. The General Assembly shall fill vacancies for which it is the appointing authority in accordance with G.S. 120-122. Appointees shall serve the remainder of the unexpired term and until their successors have been appointed and qualified.

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

(g) Compensation. – Each member of the Board shall receive such per diem compensation and reimbursement for travel and subsistence as shall be set for licensing Board members generally, as provided in G.S. 93B-5.

(h) Officers. – The officers of the Board shall be a chairman, a vice-chairman, and other officers deemed necessary by the Board to carry out the purposes of this Chapter. All officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(i) Meetings. – The Board shall hold at least two meetings each year to conduct business and shall adopt rules governing the calling, holding, and conducting of regular and special meetings. A majority of the Board members shall constitute a quorum.

(j) Employees. – The Board may employ necessary personnel for the performance of its functions, and fix their compensation, within the limits of the funds available to the Board.

(k) The total expense of the administration of this Chapter shall not exceed the total income from fees collected pursuant to this Chapter. None of the expenses of the Board, or the compensation or expenses of any officer or any employee of the Board, shall be paid or payable out of the General Fund. Neither the Board nor any of its officers or employees may incur any expense, debt, or other financial obligation binding upon the State.

"**§ 90C-24. Powers of the Board.**

(a) The Board shall have the following general powers and duties:

(1) To administer this Chapter.

(2) To issue interpretations of this Chapter.

(3) To adopt, amend, or repeal rules and regulations in the manner prescribed by Chapter 150B of the General Statutes, as may be necessary to carry out the provisions of this Chapter.

(4) To establish qualifications of, employ, and set the compensation of the Executive Director who shall not be a member of the Board.

(5) To employ and fix the compensation of the personnel that the Board determines are necessary to carry out the provisions of this Chapter and to incur other expenses necessary to effectuate this Chapter.

(6) To determine the qualifications of persons who are licensed pursuant to this Chapter.

(7) To issue, renew, deny, suspend, or revoke licenses and carry out any of the other actions authorized by this Chapter.

(8) To conduct investigations for the purpose of determining whether violations of this Chapter are grounds for revoking, denying, suspending, or refusing to renew the licenses of persons licensed pursuant to this Chapter.

(9) To maintain a record of all proceedings and make available to persons who hold a license and other concerned parties an annual report of all Board action.

(10) To set fees for licensure, license renewal, and other services deemed necessary to carry out the purpose of this Chapter.

(11) To adopt a seal containing the name of the Board to be used on licenses and official reports it issues.

(12) To issue annually a list stating the names of persons currently licensed under the privilege of this Chapter.

(13) To establish or approve, as defined by rule, reasonable competency requirements for licensure, including the power to adopt or use examination materials, study or training courses, and standards of recognized accrediting and credentialing agencies and professional associations and the power to establish or approve, as defined by rule, reasonable standards for renewal of licensure, including requirements for continuing recreational therapy or therapeutic recreation education.

(b) The powers and duties enumerated above are granted for the purpose of enabling the Board to protect the public from misrepresentation of licensure status as provided in this Chapter and shall be liberally construed to accomplish this objective.

"**§ 90C-25. Executive Director.**

The Executive Director shall deposit all fees payable to the Board in financial institutions designated by the Board as official depositories. The funds shall be deposited in the name of the Board and shall be used to pay all expenses incurred by the Board in carrying out the purposes of this Chapter. The State Auditor shall audit the Board annually.

"**§ 90C-26. The Board may accept contributions, etc.**

The Board may accept grants, contributions, devises, bequests, and gifts that shall be kept in a separate fund and shall be used by it to publicize the licensure program and its protective benefits to the public.

"**§ 90C-27. Requirements for licensure.**

(a) The Board shall license any person as a 'Licensed Recreational Therapist' who meets the following education, credential, and experience requirements:

(1) Passage of an appropriate examination as a therapeutic recreation specialist or a recreational therapist by the North Carolina Recreational Therapy Licensure Board or current certification as a 'Certified Therapeutic Recreation Specialist' by the National Council for Therapeutic Recreation Certification.

(2) A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations.

(3) For purposes of this subsection, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having a bachelors or masters degree with a specialization in recreational therapy or therapeutic recreation.

(b) The Board shall license any person as a 'Licensed Recreational Therapy Assistant' who meets the following education and experience requirements:

(1) A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines

promulgated by professional associations and credentialing and accrediting organizations as deemed appropriate by the Board.

(2) For purposes of this section, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having associate degree curricula in recreational therapy or therapeutic recreation.

"**§ 90C-28. Licensure fees.**

Applications for licensure shall be made on forms prescribed and furnished by the Board. The Board may establish fees for the actual cost of duplication services, materials, and returned bank items. All fees derived from services provided by the Board under the provisions of this Chapter shall be nonrefundable. The Board shall establish the amount of fees as defined by rule not to exceed the following amounts:

(1)	Initial application for licensure fee	$200.00
(2)	Licensure renewal fee	$200.00
(3)	Record maintenance fee	$100.00
(4)	Inactive fee	$ 50.00.

"**§ 90C-29. License renewal.**

Every license issued pursuant to this Chapter shall be renewable every two years. Within 30 days before the expiration date, a person who desires to continue to be licensed in the field of therapeutic recreation or recreational therapy shall apply for license renewal on forms furnished by the Board. The applicant shall meet criteria for renewal, including continuing education, established by the Board as defined by rule and shall pay the required fee established by the Board pursuant to this Chapter. Failure to renew the license before the expiration date shall result in automatic forfeiture of any license issued pursuant to this Chapter.

The Executive Director shall notify, in writing, every person at his or her last known address of the expiration of his or her license and the amount that is required for its two-year renewal.

"**§ 90C-30. Reinstatement.**

A person who has allowed his or her license to lapse by failure to renew it pursuant to this Chapter must apply for licensure on a reinstatement form provided by the Board. The Board shall require the applicant to return the completed reinstatement licensure form including renewal requirements established by the Board as defined by rule. If the license has lapsed for more than two years, the Board shall require the applicant to successfully demonstrate competency as defined by rules established by the Board. If the Board determines that the license should be reinstated, it shall issue a license renewal to the applicant.

"**§ 90C-31. Inactive list.**

When a person licensed by the Board submits a request for inactive status and pays the inactive fee, the Board shall issue to the person a statement of inactive status and shall place the person's name on the 'Inactive Status' list. While on that list, the person shall not hold himself or herself out as licensed pursuant to this Chapter. When that person desires to be removed from the inactive list and returned to an active list, an

application shall be submitted to the Board on a form furnished by the Board, and the fee shall be paid for license renewal. The Board shall require evidence of competency as defined by rule to resume practice before returning the applicant to the active status.

"**§ 90C-32. Revocation, suspension, or denial of licensure.**

The Board may require remedial education, issue of a letter of reprimand, restrict, revoke, or suspend any license issued pursuant to this Chapter or deny any application for licensure if the Board determines that the licensee or applicant has done any of the following:

(1) Given false information or has withheld material information from the Board in procuring or attempting to procure a license pursuant to this Chapter.

(2) Been convicted of, or pleaded guilty or nolo contendere to, any crime that indicates that the person is unfit or incompetent to be licensed pursuant to this Chapter.

(3) Is unable to perform the functions for which a license has been issued due to impairment of mental or physical faculties.

(4) Engaged in conduct that endangers the public health.

(5) Is unfit or incompetent to be licensed pursuant to this Chapter by reason of deliberate or negligent acts or omissions regardless of whether active injury to the patient or client is established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of claiming licensed status or practicing recreational therapy.

(7) Willfully violated any provision of this Chapter, rules, or code of ethics enacted by the Board.

(8) Aided, abetted, or assisted any person in violating the provisions of this Chapter.

The Board may reinstate a revoked license or remove licensure restrictions when it finds that the reasons for revocation or restriction no longer exist and that the person can reasonably be expected to safely and properly practice recreational therapy.

"**§ 90C-33. Reciprocity.**

The Board may grant a license, without examination or by special examination, to any person who, at the time of application, is licensed as a recreational therapist or therapeutic recreation specialist by a similar Board of another country, state, or territory whose licensing standards are substantially equivalent to or higher than those required by this Chapter. The Board shall determine the substantial equivalence upon which reciprocity is based.

"**§ 90C-34. Persons and practices not affected.**

Nothing in this Chapter shall be construed to prevent or restrict:

(1) Any person qualified, registered, certified, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, or licensed to engage in another profession or occupation in this State from performing work incidental to the practice of that profession or occupation as long as that person does not represent himself or herself as a recreational

therapy assistant or recreational therapist or the work to be recreational therapy or therapeutic recreation as defined by this Chapter.

(2) Any person employed as a therapeutic recreation specialist, therapeutic recreation assistant, or recreational therapist or a recreational therapy assistant by the government of the United States, if he or she provides therapeutic recreation or recreational therapy solely under the direction and control of the organization by which he or she is employed.

(3) Any person pursuing a course of study leading to a degree in recreational therapy or therapeutic recreation at an accredited college or university that meets the minimum academic requirements for a major or specialization in recreational therapy as defined by the rules and regulations of the Board.

(4) Any person fulfilling the supervised fieldwork experience required for a degree and for licensure, as defined by the rules of the Board, if the person is designated by a title that clearly indicates his or her status as a student.

"**§ 90C-35. Reports; immunity from suit.**

Any person who has reasonable cause to suspect malpractice, misconduct, or incapacity of a person who is licensed pursuant to this Chapter or who has reasonable cause to suspect that any person is in violation of this Chapter should report the relevant facts to the Board. Upon receipt of a charge or upon its own initiative, the Board may give notice of an administrative hearing pursuant to Chapter 150B of the General Statutes or may, after diligent investigation, dismiss unfounded charges. Any person making a report pursuant to this section shall be immune from criminal prosecution or civil liability based on that report unless the person knew the report was false or acted in reckless disregard of whether or not the report was false.

"**§ 90C-36. Violations and penalties.**

Any person not licensed under this Chapter who holds himself or herself out to be licensed under this Chapter or who practices recreational therapy or therapeutic recreation shall be guilty of a Class 1 misdemeanor. Any fine imposed as a result of conviction shall not exceed five hundred dollars ($500.00).

"**§ 90C-37. Enjoining illegal practices.**

(a) If the Board finds that a person is violating any of the provisions of this Chapter, it may apply in its own name to the superior court for a temporary or permanent restraining order or an injunction to prevent that person from continuing the illegal practices. The court is empowered to grant an injunction regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation. All actions by the Board shall be governed by the Rules of Civil Procedure.

(b) The venue for actions brought under this Chapter shall be in the county where the defendant resides or the county where the violation occurs."

SECTION 3. Members serving on the North Carolina State Board of Therapeutic Recreation Certification on the effective date of this act shall continue to serve and complete their current terms on the North Carolina Recreational Therapy Licensure Board established in G.S. 90C-23, as enacted in Section 2 of this act. The

Governor shall appoint the physician member to serve a three-year term pursuant to G.S. 90C-23(b)(4), as enacted in Section 2 of this act. Members appointed thereafter shall serve three-year staggered terms.

SECTION 4. Any current State-certified person working within the scope of recreational therapy, as defined in G.S. 90C-22(7), as enacted in Section 2 of this act, as a recreational therapist or a recreational therapy assistant before January 30, 2006, may be exempt from all educational, examination, and experience requirements for initial licensure pursuant to this Chapter, as enacted in Section 2 of this act. In order to qualify for this exemption, an applicant must apply to the Board for licensure before January 15, 2008, and the applicant must be working within the scope of recreational therapy and previously certified by the Board at the time of application. The Board shall attempt in good faith to notify all current State-certified persons of the availability of this exemption and the deadlines for qualifying and applying for licensure under this act.

SECTION 5. This act becomes effective October 1, 2005.

HOUSE BILL 613:
Update Certification/Licensure/Rec. Therapy

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 15, 2005
Introduced by:	Reps. Harrell, Womble	**Summary by:**	Shawn Parker
Version:	Second Edition		Committee Staff

SUMMARY: House Bill 613 updates the laws regulating the practice of recreational therapy. The bill increases the maximum licensure application from $50 to $200 and the maximum renewal fee from $25 to $200. The bill deletes a $25 reinstatement fee and a $10 certificate replacement fee and adds a new maximum record maintenance fee of $100 and an inactive fee of $50.

BILL ANALYSIS: House Bill 613 rewrites Chapter 90C of the General Statutes as follows:

- Changes the name of the Chapter from "Therapeutic Recreation Personnel Certification Act" to "North Carolina Recreational Therapy Licensure Act.
- Changes certification to licensure and changes the titles of licensees. The current law authorizes certification as a therapeutic recreation specialist or a therapeutic recreation assistant. HB 613 authorizes the licensure of a recreational therapist and licensed recreational therapy assistant and defines a recreational therapy aide as a non-licensed person who aids in providing recreational therapy services under the direct supervision of a licensed recreational therapist or licensed recreational therapy assistant.
- Adds an additional member to the current seven-member Board. The new member shall be appointed by the Governor and must be a physician licensed in North Carolina.
- Gives the Board a power to:
  - Issue annually a list of persons currently licensed under the Chapter.
  - Establish or approve competency requirements for licensure, including examinations and continuing education.
- Sets out the requirements for licensure as a recreational therapist or recreational therapy assistant. Any current State-certified person working in the scope of recreational therapy before January 30, 2006, is exempt from all educational, examination, and experience requirements for initial licensure under the Chapter if the person applies to the Board for licensure before January 15, 2008. The applicant must also be working within the scope of recreational therapy and previously certified by the Board at the time of application.
- Amends the maximum fees of the Board as follows:

Current Maximum Fees		Proposed Maximum Fees	
Certification as a therapeutic recreation specialist or as a therapeutic recreation assistant	$50	Initial licensure	$200
		Licensure renewal fee	$200
Certificate renewal	$25	Record maintenance fee	$100
Reinstatement of lapsed or expired certificate	$25	Inactive fee	$ 50
Replacement certificate	$10		

- Provides that the Chapter does not apply to incidental work by person licensed in another profession, federal employees, or students pursuing a degree in recreational therapy and fulfilling supervised fieldwork requirements.
- Makes it a Class 1 misdemeanor with a maximum fine of $500 for a person not licensed under the Chapter to represent himself or herself as licensed or to practice recreational therapy or therapeutic recreation. Current law provides for a maximum fine of $500 and/or imprisonment not to exceed 60 days.

EFFECTIVE DATE: October 1, 2005

Martha Walston contributed significantly to this analysis.

H0613e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

Legislative Fiscal Note

BILL NUMBER: House Bill 613 (First Edition)

SHORT TITLE: Update Certification/Licensure/Rec. Therapy.

SPONSOR(S): Representatives Womble and Harrell

FISCAL IMPACT

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

	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
REVENUES:					
General Fund			*No General Fund Impact*		
Licensing board	**$62,400**	**$53,450**	**$54,000**	**$44,750**	**$55,000**
EXPENDITURES:					
General Fund					
Dept. of Correction	Exact amount cannot be determined; no substantial impact anticipated.				
Judicial Branch	Exact amount cannot be determined; no substantial impact anticipated.				
POSITIONS (cumulative):	Exact amount cannot be determined; no additional positions anticipated.				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: North Carolina Recreational Therapy Licensure Board; Department of Correction; Judicial Branch

EFFECTIVE DATE: October 1, 2005

BILL SUMMARY: Creates the North Carolina Recreational Therapy Licensure Board and sets a maximum fee schedule for licensure and license renewal of recreational therapists. Elevates the penalty for violations of Chapter 90C from a Class 2 to Class 1 misdemeanor.

ASSUMPTIONS AND METHODOLOGY: There are currently 734 national board-certified recreational therapists in North Carolina, 500 of which are also state-certified. Under this bill, all practicing recreational therapists in the state will be required to obtain state licensure. The 500 recreational therapists who already hold state certification will be grandfathered in and will not have to pay an initial licensure fee; however, the licensure board expects most will elect to pay their renewal fee soon after this legislation is enacted. The following table details the number of recreational therapists in North Carolina either required or expected to pay fees over the next five years.

Number of Recreational Therapists Subject to Selected Fees (by FY)					
	2005-06	2006-07	2007-08	2008-09	2009-10
Total initial licenses	269	35	40	40	40
Total renewals	350	185	385	190	390
Record maintenance	0	619	220	425	230
Inactive	10	10	10	10	10

The projection assumes 35 new recreational therapists will seek licensure in North Carolina each year through 2008, after which the projection assumes a slight increase to 40 new recreational therapists per year. Licenses are renewed on a biannual basis. The record maintenance fee is also biannual and is staggered to fall between license renewal years.

The board does not intend to assess fees at the maximum statutory limitation set forth in this bill. Their proposed fee schedule is as follows:

Proposed Fee Schedule		
	Statutory limit	Actual fee
Initial application for licensure	$200	$100
Licensure renewal	$200	$100
Record maintenance	$100	$50
Inactive fee	$50	$50

Using the actual fees set forth in the far-right column, the table below shows the board's projected annual revenues. The board will operate entirely on fee revenue and its activities will not have any effect on the General Fund.

Total Projected Fee Revenues 2005-2010					
	2005-06	2006-07	2007-08	2008-09	2009-10
Total initial licenses	$ 26,900	$ 3,500	$ 4,000	$ 4,000	$ 4,000
Total renewals	35,000	18,500	38,500	19,000	39,000
Record maintenance	-	30,950	11,000	21,250	11,500
Inactive	500	500	500	500	500
Total fee revenue	**$ 62,400**	**$ 53,450**	**$ 54,000**	**$ 44,750**	**$ 55,000**

Expenditures

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 2005 projections. These projections are based on historical information on incarceration and release rates under Structured Sentencing, crime rate forecasts by a technical advisory group, 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.*

Violations under this bill are expected to be substantially similar to violations under existing Chapter 90C and, as such, no additional convictions would be expected. Presently, the Administrative Office of the Courts does not maintain an offense code for violations of Chapter 90C, which is some indication that these offenses are infrequently charged and rarely result in convictions. However, convictions would be elevated from Class 2 to Class 1 misdemeanors due to this bill.

- In FY 2003-04, 19 percent of Class 1 as opposed to 15 percent of Class 2 misdemeanors resulted in active sentences and the average estimated time served was 31 days as opposed to 13 days for Class 2.
- Offenders with active sentences of less than ninety days are housed in county jails, and DOC reimburses counties for housing offenders between thirty and ninety days at a rate of $18 per offender per day. As such, sentences elevated from Class 2 to Class 1 misdemeanors would be expected to increase payments to counties by DOC.
- The remaining 81 percent of Class 1 misdemeanants received non-active sentences. For those offenders sentenced to supervised probation, the Division of Community Corrections (DCC) would incur costs of $1.87 per offender per day. Offenders sentenced to community service would cost $0.67 per offender per day, and offenders given unsupervised probation would not impact DCC.

Because most Class 1 misdemeanants serving active time as a result of this bill would be housed in county jails, this legislation is not expected to significantly impact prison population.

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 AOC does not maintain an offense code for present violations of Chapter 90C, there is no historical data regarding Class 1 misdemeanor charges for these offenses. However, the lack of an offense code may be some indication that there are few charges for these offenses. As such, the number of charges elevated from Class 2 to Class 1 misdemeanors due to this bill is not expected to be substantial.

Based on the costs of time in court, attorney preparation time, and indigent defense, the average estimated increase in cost to dispose of a single charge via trial that is elevated from a Class 2 to Class 1 misdemeanor is $891. This cost includes an estimated increase of $507 for costs of time in court and attorney preparation and an additional $384 in indigent defense. *However, based on prior-year data, the majority of charges under this bill that are not dismissed are likely to be settled by guilty plea at an estimated increase in cost of $8 per plea.*

SOURCES OF DATA: North Carolina Therapeutic Recreation Certification Board; Department of Correction; Administrative Office of the Courts

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Brenna Erford and Aaron Paul

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

DATE: May 16, 2005

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 874

Committee Substitute Favorable 5/11/05

Short Title: Title Change/Safety and Health Review Board. (Public)

Sponsors:

Referred to:

March 24, 2005

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE TITLE OF THE SAFETY AND HEALTH REVIEW BOARD UNDER THE OCCUPATIONAL SAFETY AND HEALTH ACT OF NORTH CAROLINA TO THE NORTH CAROLINA OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION, TO CHANGE THE TITLE OF THE OFFICE OF OCCUPATIONAL SAFETY AND HEALTH TO THE OCCUPATIONAL SAFETY AND HEALTH DIVISION, AND TO RESTORE THE AUTHORITY OF THE BOARD TO ASSESS PENALTIES IN THE CASE OF AN APPEAL.

The General Assembly of North Carolina enacts:

SECTION 1. Under the Occupational Safety and Health Act of North Carolina, the name of the Safety and Health Review Board is changed to the North Carolina Occupational Safety and Health Review Commission. The Revisor of Statutes is authorized to substitute the term "Commission" for the term "Board" wherever that term appears in the General Statutes in relation to the Act.

SECTION 2. G.S. 95-126(b)(2) reads as rewritten:

"(b) Legislative findings and purpose:

...

(2) The General Assembly of North Carolina declares it to be its purpose and policy through the exercise of its powers to ensure so far as possible every working man and woman in the State of North Carolina safe and healthful working conditions and to preserve our human resources:

a. By encouraging employers and employees in their effort to reduce the number of occupational safety and health hazards at the place of employment, and to stimulate employers and employees to institute new and to perfect existing programs for providing safe and healthful working conditions;

b. By providing that employers and employees have separate but dependent responsibilities and rights with respect to achieving safe and healthful working conditions;

c. By authorizing the Commissioner to develop occupational safety and health standards applicable to business giving consideration to the needs of employers and employees and to adopt standards promulgated from time to time by the Secretary of Labor under the Occupational Safety and Health Act of 1970, and by creating a safety and health review ~~board~~ commission for carrying out adjudicatory functions under this Article;

d. By building upon advances already made through employer and employee initiative for providing safe and healthful working conditions;

e. By providing occupational health criteria which will assure insofar as practicable that no employee will suffer diminished health, functional capacity, or life expectancy as a result of his work experience;

f. By providing for training programs to increase the number and competence of personnel engaged in the field of occupational safety and health;

g. By providing an effective enforcement program which shall include a prohibition against giving advance notice of an inspection and sanctions for any individual violating this prohibition;

h. By providing for appropriate reporting procedures with respect to occupational safety and health which procedures will help achieve the objectives of this Article and accurately describe the nature of the occupational safety and health problem;

i. By encouraging joint employer-employee efforts to reduce injuries and diseases arising out of employment;

j. By providing for research in the field of occupational safety and health, by developing innovative methods, techniques, and approaches for dealing with occupational safety and health problems;

k. By exploring ways to discover latent diseases, establishing causal connections between diseases and work in environmental conditions, and conducting other research relating to health problems, in recognition of the fact that occupational health standards present problems often different from those involved in occupational safety;

l. By authorizing the Commissioner to enter into contracts with the Department of Health and Human Services, or any other State or local units, to the end the Commissioner and the Department of Health and Human Services and other State or

local units may fully cooperate and carry out the ends and purposes of this Article.

m. The General Assembly of North Carolina appoints and elects the North Carolina Department of Labor as the designated agency to administer the Occupational Safety and Health Act of North Carolina."

SECTION 3. G.S. 95-127(2) reads as rewritten:

"(2) The term ~~"Board"~~'Commission' means the ~~Safety and Health Review Board~~North Carolina Occupational Safety and Health Review Commission established under this Article."

SECTION 4. G.S. 95-133 reads as rewritten:

"**§ 95-133. Office of Director of Occupational Safety and Health; powers and duties of the Director.**

(a) There is hereby created and established in the North Carolina Department of Labor a division to be known as the ~~Office of~~ Occupational Safety and ~~Health.~~ Health Division. The Commissioner shall appoint a Director to administer this division who shall be subject to the direction and supervision of the Commissioner. The Director shall carry out the responsibilities of the State of North Carolina as prescribed under the Occupational Safety and Health Act of 1970, and any subsequent federal laws or regulations relating to occupational safety and health, and this Article, as written, revised or amended by legislative enactment and as delegated or authorized by the Commissioner. The Commissioner shall make and promulgate such rules, amendments, or revisions in rules, as he may deem advisable for the administration of the office, he shall also accept and use the services, facilities, and personnel of any agency of the State or of any subdivision of State government, either as a free service or by reimbursement. The Director shall devote full time to his duties of office and shall not hold any other office. The Director, subject to the approval of the Commissioner, shall select a professional staff of qualified and competent employees to assist in the statewide administration of the Article. All of the employees referred to herein shall be under the classified service, as herein defined in G.S. 95-127, subdivision (3).

(b) Subject to the general supervision of the Commissioner and Deputy Commissioner, the Director shall be responsible for the administration and enforcement of all laws, rules and regulations which it is the duty of the ~~Office~~ Division to administer and enforce. The Director shall have the power, jurisdiction and authority to:

(1) Uniformly superintend, enforce and administer applicable occupational safety and health laws of the State of North Carolina;

(2) Make or cause to be made all necessary inspections, analyses and research for the purpose of seeing that all laws and rules and regulations which the office has the duty, power and authority to enforce are promptly and effectively carried out;

(3) Make all necessary investigations, develop information and reports upon conditions of employee safety and health, and upon all matters relating to the enforcement of this Article and all lawful regulations issued thereunder;

(4) Report to the Federal Occupational Safety and Health Administration any information which it may require;

(5) Recommend to the Commissioner such rules, regulations, standards, or changes in rules, regulations and standards which the Director deems advisable for the prevention of accidents, occupational hazards or the prevention of industrial or occupational diseases;

(6) Recommend to the Commissioner that he institute proceedings to remove from his or her position any employee of the Office who accepts any favor, privilege, money, object of value, or property of any kind whatsoever or who shall give prior notice of a compliance inspection of a work place unless authorized under the provisions of this Article;

(7) Employ experts, consultants or organizations for work related to the occupational safety and health program of the ~~Office~~ Division and compensate same with the approval of the Commissioner;

(8) Institute hearings, investigations, request the issuance of citations and propose such penalties as he may in his judgment consider necessary to carry out the provisions of this Article;

(9) The Commissioner shall have the power and authority to issue all types of notices, citations, cease and desist orders, or any other pleading, form or notice necessary to enforce compliance with this Article as hereinafter set forth. The Commissioner is also empowered and authorized to apply to the courts of the State having jurisdiction for orders or injunctions restraining unlawful acts and practices prohibited by this Article or not in compliance with this Article and to apply for mandatory injunctions to compel enforcement of the Article, and the Commissioner is authorized, and further authorized by and through his agents, to institute criminal actions or proceedings for such violations of the Article as are subject to criminal penalties. The Director shall recommend to the Commissioner the imposition and amount of civil penalties provided by this Article, and the Commissioner may institute such proceedings as necessary for the enforcement and payment of such civil penalties subject to such review of the ~~Board~~ Commission as hereinafter set forth.

(10) The Director may recommend to the Commissioner that any person, firm, corporation or witness be cited for contempt or for punishment as of contempt, and the Commissioner is authorized to enter any order of contempt or as of contempt as he may deem proper and necessary, and any hearing examiner may recommend to the Commissioner that such order or citation for contempt be made.

(11) The Commissioner or the Director, or their authorized agents, shall have the power and authority to issue subpoenas for witnesses and for the production of any and all papers and documents necessary for any hearing or other proceeding and to require the same to be served by the

process officers of the State. The Commissioner and the Director may administer any and all oaths that are necessary in the enforcement of this Article and may certify as to the authenticity of all records, papers, documents and transcripts under the seal of the Department of Labor.

(12) All orders, citations, cease and desist orders, stop orders, sanctions and contempt orders, civil penalties and the proceedings thereon shall be subject to review by the ~~Board~~ Commission as hereinafter provided, including all assessments for civil penalties."

SECTION 5. G.S. 95-135 reads as rewritten:

"**§ 95-135. ~~Safety and Health Review Board.~~North Carolina Occupational Safety and Health Review Commission.**

(a) The ~~Safety and Health Review Board~~North Carolina Occupational Safety and Health Review Commission is hereby established. The ~~Board~~ Commission shall be composed of three members from among persons who, by reason of training, education or experience, are qualified to carry out the functions of the ~~Board~~ Commission under this Article. The Governor shall appoint the members of the ~~Board~~ Commission and name one of the members as chairman of the ~~Board.~~Commission. The terms of the members of the ~~Board~~ Commission shall be six years except that the members of the ~~Board~~ Commission first taking office shall serve, as designated by the Governor at the time of appointment, one for a term of two years, one for a term of four years, and the member of the ~~Board~~ Commission designated as chairman shall serve for a term of six years. Any vacancy caused by the death, resignation, or removal of a member prior to the expiration of the term for which he was appointed shall be filled by the Governor for the remainder of the unexpired term. The Governor shall fill all vacancies occurring by reason of the expiration of the term of any members of the ~~Board.~~Commission.

(b) The ~~Board~~ Commission shall hear and issue decisions on appeals entered from citations and abatement periods and from all types of penalties. Appeals from orders of the Director dealing with conditions or practices that constitute imminent danger shall not be stayed by the ~~Board~~ Commission until after full and adequate hearing. The ~~Board~~ Commission in the discharge of its duties under this Article is authorized and empowered to administer oaths and affirmations and institute motions, cause the taking of depositions, interrogatories, certify to official acts, and issue subpoenas to compel the attendance of witnesses and the production of books, papers, correspondence, memoranda, and other records deemed necessary as evidence in connection with any appeal or proceeding for review before the ~~Board.~~Commission.

(c) The ~~Board~~ Commission shall meet at least once each calendar quarter but it may hold call meetings or hearings upon at least three days' notice to each member by the chairman and at such time and place as the chairman may fix. The chairman shall be responsible on behalf of the ~~Board~~ Commission for the administrative operations of the ~~Board~~ Commission and shall appoint such hearing examiners and other employees as he deems necessary to assist in the performance of the ~~Board's~~ Commission's functions and fix the compensation of such employees with the approval of the Governor. The assignment and removal of hearing examiners shall be made by the ~~Board,~~Commission, and any hearing examiner may be removed for misfeasance, malfeasance, misconduct,

immoral conduct, incompetency, the commission of any crime, or for any other good and adequate reason as found by the ~~Board.~~Commission. The ~~Board~~ Commission shall give notice to such hearing examiner, along with written allegations as to the charges against him, and the same shall be heard by the ~~Board,~~Commission, and its decision shall be final. The compensation of the members of the ~~Board~~ Commission shall be on a per diem basis and shall be fixed by the Governor. The chairman of the ~~Board~~ Commission may be paid a higher rate of compensation than the other two members of the ~~Board.~~Commission. For the purpose of carrying out its duties and functions under this Article, two members of the ~~Board~~ Commission shall constitute a quorum and official action can be taken only on the affirmative vote of at least two members of the ~~Board.~~Commission. On matters properly before the ~~Board~~ Commission the chairman may issue temporary orders, subpoenas, and other temporary types of orders subject to the subsequent review of the ~~Board.~~Commission. The issuance of subpoenas, orders to take depositions, orders requiring interrogatories and other procedural matters of evidence issued by the chairman shall not be subject to review. Prior to taking any action under this subsection to set compensation, the Governor may consult with the Advisory Budget Commission.

(d) Every official act of the ~~Board~~ Commission shall be entered of record and its hearings and records shall be open to the public. The ~~Board~~ Commission is authorized and empowered to make such procedural rules as are necessary for the orderly transaction of its proceedings. Unless the ~~Board~~ Commission adopts a different rule, the proceedings, as nearly as possible, shall be in accordance with the Rules of Civil Procedure, G.S. 1A-1. The ~~Board~~ Commission may order testimony to be taken by deposition in any proceeding pending before it at any stage of such proceeding. Any person, firm or corporation, and its agents or officials, may be compelled to appear and testify and produce like documentary evidence before the ~~Board.~~Commission. Witnesses whose depositions are taken under this section, and the persons taking such depositions, shall be entitled to the same fees as are paid for like services in the courts of the State.

(e) The rules of procedure prescribed or adopted by the ~~Board~~ Commission shall provide affected employees or representatives of affected employees an opportunity to participate as parties to hearings under this section.

(f) Any member of the ~~Board~~ Commission may be removed by the Governor for inefficiency, neglect of duty, or any misfeasance or malfeasance in office. Before such removal the Governor shall give notice of hearing and state the allegations against the member of the ~~Board,~~Commission, and the same shall be heard by the Governor, and his decision shall be final. The principal office of the ~~Board~~ Commission shall be in Raleigh, North Carolina, but whenever it deems that the convenience of the public or of the parties may be promoted, or delay or expense may be minimized, the ~~Board~~ Commission may hold hearings or conduct other proceedings at any place in the State.

(g) In case of a contumacy, failure or refusal of any person to testify before the ~~Board,~~Commission, give any type of evidence, or to produce any books, records, papers, correspondence, memoranda or other records, such person upon such failure to obey the orders of the ~~Board~~ Commission may be punished for contempt or any other

matter involving contempt as set forth and described by the general laws of the State. The ~~Board~~ Commission shall issue no order for contempt without first finding the facts involved in the proceeding. Witnesses appearing before the ~~Board~~ Commission shall be entitled to the same fees as those paid for the services of said witnesses in the courts of the State, and all such fees shall be taxed against the interested parties according to the judgment and discretion of the ~~Board.~~Commission.

(h) The Director shall consult with the chairman of the Board with respect to the preparation and presentation to the ~~Board~~ Commission for adoption of all necessary forms or citations, notices of all kinds, forms of stop orders, all forms and orders imposing penalties and all forms of notices or applications for review by the ~~Board,~~Commission, and any and all other procedural papers and documents necessary for the administration of the Article as applied to employers and employees and for all procedures and proceedings brought before the ~~Board~~ Commission for review.

(i) A hearing examiner appointed by the chairman of the ~~Board~~ Commission shall hear, and make a determination upon, any proceeding instituted before the ~~Board~~ Commission and may hear any motion in connection therewith, assigned to the hearing examiner, and shall make a report of the determination which constitutes the hearing examiner's final disposition of the proceedings. A copy of the report of the hearing examiner shall be furnished to the Director and all interested parties involved in any appeal or any proceeding before the hearing examiner for the hearing examiner's determination. The report of the hearing examiner shall become the final order of the ~~Board~~ Commission 30 days from the date of the report as determined by the hearing examiner, unless within the 30-day period any member of the ~~Board~~ Commission had directed that the report shall be reviewed by the entire ~~Board~~ Commission as a whole. Upon application for review of any report or determination of a hearing examiner, before the 30-day period expires, the ~~Board~~ Commission shall schedule the matter for hearing, on the record, except the ~~Board~~ Commission may allow the introduction of newly discovered evidence, or in its discretion the taking of further evidence upon any question or issue. All interested parties to the original hearing shall be notified of the date, time and place of the hearing and shall be allowed to appear in person or by attorney at the hearing. Upon review of the report and determination by the hearing examiner the ~~Board~~ Commission may adopt, modify or vacate the report of the hearing examiner and notify the interested parties. The report of the hearing examiner, and the report, decision, or determination of the ~~Board~~ Commission upon review shall be in writing and shall include findings of fact, conclusions of law, and the reasons or bases for them, on all the material issues of fact, law, or discretion presented on the record. The report, decision or determination of the ~~Board~~ Commission upon review shall be final unless further appeal is made to the courts under the provisions of Chapter 150B of the General Statutes, as amended, entitled: "Judicial Review of Decisions of Certain Administrative Agencies.

(j) Repealed by Session Laws 1993, c. 300, s. 1."

SECTION 6. G.S. 95-137(b)(2) reads as rewritten:

"(b) Procedure for Enforcement. –

...

(2) If the Director has reason to believe that an employer has failed to correct a violation for which a citation has been issued within the period permitted for its correction (which period shall not begin to run until the entry of a final order by the ~~Board~~ Commission in case of any review proceedings under this Article initiated by the employer in good faith and not solely for a delay or avoidance of penalties), the Director shall notify the employer by certified mail, by a designated delivery service authorized pursuant to 26 U.S.C. § 7502(f)(2) with delivery receipt, or via hand delivery of such failure and of the penalty proposed to be assessed under this Article by reason of such failure and that the employer has 15 working days within which to notify the Director that the employer wishes to contest the Director's notification of the proposed assessment of penalty. If, within 15 working days from the receipt of notification issued by the Director, an employer fails to notify the Director that the employer intends to contest the notification or proposed recommendation of penalty, the notification and the proposed assessment made by the Director shall be final and not subject to review by any court."

SECTION 7. G.S. 95-137(b)(4) reads as rewritten:

"(b) Procedure for Enforcement. –

...

(4) If an employer notifies the Director that the employer intends to contest a citation issued under the provisions of this Article or notification issued under the provisions of this Article, or if, within 15 working days of the receipt of a citation under this Article, any employee or representative thereof files a notice with the Director alleging that the period of time fixed in the citation for the abatement of the violation is unreasonable, the Director shall immediately advise the ~~Board~~ Commission of such notification, and the ~~Board~~ Commission shall afford an opportunity for a hearing. The ~~Board~~ Commission shall thereafter issue an order, based on findings of fact, affirming, modifying, or vacating the Director's citation or the proposed penalty fixed by the Commissioner, or directing other appropriate relief, and such order shall become final 30 days after its issuance. Upon showing by an employer of a good faith effort to comply with the abatement requirements of a citation, and that an abatement has not been completed because of factors beyond the employer's reasonable control, the Director, after an opportunity for a hearing as provided in this Article, shall issue an order affirming or modifying the abatement requirements in such citation. The rules of procedure prescribed by the chairman of the ~~Board~~ Commission shall provide affected employees or representatives of affected employees an opportunity to participate as parties to hearings under this section."

SECTION 8. G.S. 95-138 reads as rewritten:

"**§ 95-138. Civil penalties.**

(a) The ~~Commissioner,~~ Commissioner, upon recommendation of the Director, or the North Carolina Occupational Safety and Health Review Commission in the case of an appeal, may assess penalties against any employer who violates the requirements of this Article, or any standard, rule, or order promulgated pursuant to this Article, as follows:

(1) A minimum penalty of five thousand dollars ($5,000) to a maximum penalty of seventy thousand dollars ($70,000) for each willful or repeat violation.

(2) A maximum penalty of seven thousand dollars ($7,000) for each nonserious or serious violation.

(3) A maximum penalty of seven thousand dollars ($7,000) for each day that an employer fails to correct and abate a violation, within the period allowed for its correction and abatement, which period shall not begin to run until the date of the final Order of the ~~Board~~ Commission in the case of any appeal proceedings in this Article initiated by the employer in good faith and not solely for the delay of avoidance of penalties.

(4) A maximum penalty of seven thousand dollars ($7,000) for violating the posting requirements, as required under the provisions of this Article.

(b) The Commissioner shall adopt uniform standards that the Commissioner, the ~~Board,~~ Commission, and the hearing examiner shall apply when determining appropriateness of the penalty. The following factors shall be used in determining whether a penalty is appropriate:

(1) Size of the business of the employer being charged.

(2) The gravity of the violation.

(3) The good faith of the employer.

(4) The record of previous violations; provided that for purposes of determining repeat violations, only the record within the previous three years is applicable.

The report of the hearing examiner and the report, decision, or determination of the ~~Board~~ Commission on appeal shall specify the standards applied in determining the reduction or affirmation of the penalty assessed by the Commissioner.

(c) The clear proceeds of all civil penalties and interest recovered by the Commissioner, together with the costs thereof, shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 9. G.S. 95-152 reads as rewritten:

"**§ 95-152. Confidentiality of trade secrets.**

All information reported to or otherwise obtained by the Commissioner or his agents or representatives in connection with any inspection or proceeding under this Article which contains or which might reveal a trade secret shall be considered confidential, as provided by section 1905 of Title 18 of U.S.C., except as to carrying out this Article or when it is relevant in any proceeding under this Article. In any such proceeding the

Commissioner, the ~~Board~~ Commission, or the court shall issue such orders as may be appropriate to protect the confidentiality of trade secrets."

SECTION 10. G.S. 150B-1(e)(9) reads as rewritten:

"(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(9) ~~The Occupational Safety and Health Review Board.~~The North Carolina Occupational Safety and Health Review Commission."

SECTION 11. This act is effective when it becomes law.

HOUSE BILL 874:
Title Change/Safety and Health Review Board

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 14, 2005
Introduced by:	Rep. Goodwin	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: ***House Bill 874 changes the title of the Safety and Health Review Board under the Occupational Safety and Health Act of North Carolina to the North Carolina Occupational Safety and Health Review Commission. The bill authorizes, in the case of an appeal, the North Carolina Occupational Safety and Health Review Commission to assess penalties against any employer who violates the Act.***

CURRENT LAW: Article 16 of Chapter 95 of the North Carolina General Statutes governs the provisions of the Occupational Safety and Health Act of North Carolina. "The General Assembly declares its purpose and policy through the exercise of its powers to ensure, so far as possible every working man and woman in the State of North Carolina safe and healthful working conditions..."[1].

BILL ANALYSIS: The bill changes the title of the Safety and Health Review Board under the Occupational Safety and Health Act to the North Carolina Occupational Safety and Health Review Commission. Throughout the bill the following changes were made to conform with the title change:

- The term "board" is replaced with the term "commission".
- The term "office" is replaced with the term "division".
- The phrase "Safety and Health Review Board" is replaced with the phrase "North Carolina Occupational Safety and Health Review Commission".

The bill authorizes the North Carolina Occupational Safety and Health Review Commission to assess penalties against any employer who violates the Occupational Safety and Health Act in the case of an appeal.

EFFECTIVE DATE: The act is effective when it becomes law.

BACKGROUND: "The Safety and Health Review Board was established in 1973 by the Occupational Safety and Health Act of North Carolina. That act also created a Division of Occupational Safety and Health within the Department of Labor, and the North Carolina State Advisory Council on Occupational Safety and Health. Decisions of the Safety and Health Review Board are published in volumes entitled *North Carolina Occupational Safety and Health Decisions*. At the federal level the Williams-Steiger Occupational Safety and Health Administration of 1970 established the Occupational Safety and Health Administration as well as the National Institute for Occupational Safety and Health. Also created was an independent adjudicatory body, the U.S. Occupational Safety and Health Review Commission, whose mission and activity are comparable to that of the Safety and Health Review Board of North Carolina."[2]

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[1] G.S. 95-126(a)(2)

[2] Memorandum produced by the Safety and Health Review Board of North Carolina

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1357

Committee Substitute Favorable 5/10/05

Short Title: Amend Acupuncture Laws/Fees. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE ACUPUNCTURE LICENSING BOARD TO EMPLOY CERTAIN PROFESSIONAL ADVISORS; TO CLARIFY QUALIFICATIONS FOR INITIAL LICENSURE, LICENSE RENEWAL, AND INACTIVE, SUSPENDED, EXPIRED, AND LAPSED LICENSES; TO CLARIFY CONTINUING EDUCATION; AND TO INCREASE AND ESTABLISH CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-454 reads as rewritten:

"**§ 90-454. Powers and duties of Board.**

The Board may:

(1) Deny, issue, suspend, and revoke licenses in accordance with rules adopted by the Board, and may collect fees, investigate violations of this Article, and otherwise administer the provisions of this Article.

(2) Sponsor or authorize other entities to offer continuing education programs, and approve continuing education requirements for license renewal.

(3) Establish requirements ~~for~~ for, collect fees from, and approve schools of acupuncture in this State. The requirements shall be at least as stringent as the core curricula standards of the Council of Colleges of Acupuncture and Oriental Medicine.

(4) Sue to enjoin violations of G.S. 90-452. The court may issue an injunction even though no person has yet been injured as a result of the unauthorized practice.

(5) Adopt and use a seal to authenticate official documents of the Board.

(6) Employ and fix the compensation of personnel and professional advisors, including legal counsel, as may be needed to carry out its functions, and purchase, lease, rent, sell, or otherwise dispose of personal and real property for the operations of the Board.

(7) Expend funds as necessary to carry out the provisions of this Article from revenues and interest generated by fees collected under this Article.

(8) Adopt rules to implement this Article in accordance with Chapter 150B of the General Statutes.

(9) Establish practice parameters to become effective July 1, 1995. The practice parameters shall be applicable to general and specialty areas of practice. The Board shall review the parameters on a regular basis and shall require licensees to identify parameters being utilized, the plan of care, and treatment modalities utilized in accordance with the plan of care."

SECTION 2. G.S. 90-455 reads as rewritten:

"**§ 90-455. Qualifications for license; ~~renewal.~~renewal; inactive, suspended, expired, or lapsed license.**

(a) Initial License. – To receive a license to practice acupuncture, a person shall meet all of the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) ~~Successfully complete~~Submit proof of successful completion of a licensing examination administered or approved by the Board.

(4) Provide documentary evidence of having met one of the following standards of education, training, or demonstrated experience:

a. ~~Successfully complete~~Successful completion of a three-year postgraduate acupuncture college or training program approved by the Board.

b. Continuous licensure to practice acupuncture by an agency or another state for at least 10 years before application for licensure in this State during which time no disciplinary actions were taken or are pending against the applicant and submitting proof to the Board that the applicant has fulfilled at least an average of 20 continuing education units in acupuncture or health care-related studies for each of the 10 years preceding application for licensure.

(5) ~~Successfully complete~~Submit proof of successful completion of the Clean Needle Technique Course offered by the Council of Colleges of Acupuncture and Oriental Medicine.

(6) Be of good moral character.

(7) Is not currently or has not engaged in any practice or conduct that would constitute grounds for disciplinary action pursuant to G.S. 90-456.

(8) Submit a form signed by the applicant attesting to the intention of the applicant to adhere fully to the ethical standards adopted by the Board.

(b) Renewal of License. – The license to practice acupuncture shall be renewed every two years. Upon submitting all required declarations, documents, and fees

required by the Board for renewal, the applicant's license shall remain in good standing for a period of up to 120 days during which time the Board shall meet to review and act upon the application for renewal. To renew a license, ~~a person shall complete 40 hours of Board-approved Continuing Education Units within each renewal period.~~an applicant shall:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Upon request by the Board, submit proof of completion of 40 hours of Board-approved continuing education units within each renewal period.

(c) Inactive License. – A licensed acupuncturist who is not actively engaged in the practice of acupuncture in this State and who does not wish to renew the license may direct the Board to place the license on inactive status. A license may remain on inactive status for a period not to exceed eight years from the date the license was placed on inactive status. Upon an applicant's proof of completion of 40 hours of Board-approved continuing education units, payment of all fees, a determination by the Board that the applicant is not engaged in any prohibited activities that would constitute the basis for discipline as set forth in G.S. 90-456, and has not engaged in any of those prohibited activities during the period of time the license has been on inactive status, the Board may activate the license of the applicant.

(d) Suspended License. – A suspended license is subject to the renewal requirements of this section and may be renewed as provided in this section. This renewal does not entitle the licensed person to engage in the licensed activity or in any other conduct or activity in violation of the order or judgment by which the license was suspended, until the license is reinstated. If a license revoked on disciplinary grounds is reinstated and requires renewal, the licensed person shall pay the renewal fee and any applicable late fee.

(e) Expired License. – A license that has expired as a result of failure to renew pursuant to subsection (b) of this section may be renewed no later than two years after its expiration. The date of renewal shall be the date the Board acts to approve the renewal. To apply for renewal of an expired license, the applicant shall:

(1) File an application for renewal on a form provided by the Board.

(2) Submit proof of completion of all continuing education requirements.

(3) Pay all accrued renewal fees, along with an expired license fee.

(f) Lapsed License. – A license that has lapsed as a result of not being renewed within two years after the license expired or not reactivated within eight years after the license lapsed is deemed inactive. A lapsed license may not be renewed, reactivated, or reinstated. A person with a lapsed license may apply to obtain a new license pursuant to subsection (a) of this section."

SECTION 3. G.S. 90-457 reads as rewritten:

"**§ 90-457. Fees.**

The Board may establish fees, not to exceed the following ~~amounts, to cover the cost of services rendered:~~amounts:

(1) ~~For an application~~Application and an examination, one hundred dollars ($100.00).
(2) ~~For issuance~~Issuance of a license, five hundred dollars ($500.00).
(3) ~~For renewal~~Renewal of a license, three hundred dollars ($300.00).
(4) ~~For the late renewal~~Renewal of a license, an additional late fee of ~~seventy-five dollars ($75.00).~~two hundred dollars ($200.00).
(5) Duplicate license fee, twenty-five dollars ($25.00).
(6) Duplicate wall certificate fee, fifty dollars ($50.00).
(7) Labels for licensed acupuncturists, one hundred fifty dollars ($150.00).
(8) Returned check fee, forty dollars ($40.00).
(9) Licensure verification, forty dollars ($40.00).
(10) Name change, twenty-five dollars ($25.00).
(11) Continuing education program approval fee, fifty dollars ($50.00).
(12) Continuing education provider approval fee, two hundred dollars ($200.00).
(13) Initial school application fee, one thousand dollars ($1,000).
(14) Renewal school approval fee, seven hundred fifty dollars ($750.00).
(15) Inactive license renewal fee, fifty dollars ($50.00), payment due for each two-year extension."

SECTION 4. Article 30 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-457.1. Continuing education.**

(a) Applicants for license renewal shall complete all required continuing education units during the two calendar years immediately preceding the license renewal date.

(b) The Board shall set the minimum hours for study of specific subjects within the scope of practice of acupuncture. The Board shall set the maximum hours for subjects that have content relating to any health service and are relevant to the practice of acupuncture. In addition to formally organized courses, the Board may approve courses, such as personal training in nonaccredited programs and teaching diagnosis and treatment, as long as these courses have received prior approval by the Board.

(c) For purposes of this Article, one continuing education unit is defined as one contact hour or 50 minutes.

(d) The Board may choose to audit the records of any licensee who has reported and sworn compliance with the continuing education requirement. The audit of any licensee shall not take place more than every two years.

(e) Failure to comply with the continuing education requirements shall prohibit license renewal and result in the license reverting to expired status at the end of the renewal period.

(f) A licensee may apply to the Board for an extension of time to complete the portion of continuing education requirements that the licensee is unable to meet due to such unforeseeable events as military duty, family emergency, or prolonged illness. The Board may, at its discretion, grant an extension for a maximum of one licensing period. The Board shall receive the request no later than 30 days before the license renewal

date. The applicant shall attest that the request is a complete and accurate statement, and the request shall contain the following:

(1) An explanation of the licensee's failure to complete the continuing education requirements.

(2) A list of continuing education courses and hours that the licensee has completed.

(3) The licensee's plan for satisfying the continuing education requirements."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1357:
Amend Acupuncture Laws/Fees.

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 25, 2005
Introduced by:	Fisher and Gibson	**Summary by:**	Shawn Parker
Version:	2nd Edition		Committee Staff

SUMMARY: House Bill 1357 makes the following changes to the statutes governing the Acupuncture Licensing Board:

- Authorizes the Board to hire professional advisors, including legal counsel, and to fix their compensation.
- Allows licensure of applicants licensed for at least 10 years in another state if the applicant has no disciplinary actions in that period and meets minimum continuing education standards.
- Adds requirements for renewal of licenses.
- Adds new language providing for an inactive license and for the renewal of suspended, expired, and lapsed licenses.
- Increases some fees related to licensure and adds new fees.

CURRENT LAW: The Acupuncture Licensing Board was established by the General Assembly in 1993. The Board is composed of six members: two appointed by the Governor and four appointed by the General Assembly. The Governor's appointees must be a layperson and a physician trained in acupuncture. The General Assembly's appointees must be non-physicians licensed to practice acupuncture.

Acupuncture is defined as a form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

BILL ANALYSIS:

Section 1 of the bill gives the Board the authority to employ professional advisors, including legal counsel, and to fix their compensation.

Section 2 of the bill amends the licensing qualifications as follows:

Initial License

- Adds language allowing licensure of an applicant who has been continuously licensed to practice acupuncture in another state for at least 10 years and who has no disciplinary actions during that time. The applicant must also have fulfilled at least an average of 20 continuing education credits for each of the 10 years preceding the application for N.C. licensure.
- Adds language requiring that the applicant be of good moral character, not currently engaged in any conduct that would constitute grounds for disciplinary action, and submit a form signed by the applicant that he or she will adhere to the ethical standards of the Board.

Renewal of License

- Adds language that when an applicant submits an application for license renewal, the applicant's license will remain in good standing for up to 120 days while the Board reviews and acts upon the application for renewal. Current law requires that a license must be renewed every two years for a fee not to exceed $300.

Inactive License, Suspended License, Expired License, and Lapsed License (This is new language)

- Inactive License – allows a licensed acupuncturist to remain on inactive status for a period not to exceed eight years. The Board may activate the license upon the applicant's completion of 40 hours of continuing education units, payment of all fees, and upon the Board's finding that the applicant has not engaged in any prohibited activity.
- Suspended License – subject to the license renewal requirements.
- Expired License – A license that has expired as a result of failure to renew may be renewed no later than two years after its expiration.
- Lapsed License – A person with a lapsed license must apply to obtain a new license and meet the requirements for initial licensure.

Section 3 of the bill amends the statute that sets out the maximum fees as follows:

- Increases the late fee for license renewal from $75 to $200.
- Adds the following new maximum fees:
  - Duplicate license fee - $25
  - Duplicate wall certificate fee - $50
  - Labels for licensed acupuncturists - $150
  - Returned check fee - $40
  - Licensure verification - $40
  - Name change - $25
  - Continuing education program approval fee - $50
  - Continuing education provider approval fee - $200
  - Initial school application fee - $1,000
  - Renewal school approval fee - $750
  - Inactive license renewal fee - $50 (Payment due for each two-year extension)

Section 4 of the bill clarifies continuing education requirements. The bill requires an applicant for renewal to complete 40 hours of continuing education units within the two-year renewal period. One unit is defined as one contact hour or 50 minutes. A licensee may apply to the Board for an extension to complete these requirements due to unforeseeable events.

EFFECTIVE DATE: The bill is effective when it becomes law.

Marha Walston contributed significantly to this analysis.

H 1357e2-SMSQ

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 1357 DATE 6/15/05

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Rand
Sen.)

moves to amend the bill on page 2, line 26

( ) WHICH CHANGES THE TITLE

by inserting after the word "agency" the following: "of another state";

and on page 2, line 27 by inserting after the word "state" the following: "whose qualifications for licensure meet or exceed those of this State".

SIGNED Tony Rand

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 673*

Short Title:	Jobs for All Act.	(Public)
Sponsors:	Senators Nesbitt; and Berger of Franklin.	
Referred to:	Health Care.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LONG-TERM VOCATIONAL SUPPORT SERVICES TO PERSONS WITH MENTAL ILLNESS AND DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

Whereas, persons with mental illness and developmental disabilities should have the dignity and responsibility conferred by work; and

Whereas, the General Assembly has legislated that best practice will be the standard for reform of the mental health system; and

Whereas, long-term vocational support services are recognized as a best practice for persons with severe disabilities; Now, therefore,

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the sum of six million dollars ($6,000,000) for the 2005-2006 fiscal year and the sum of six million dollars ($6,000,000) for the 2006-2007 fiscal year. These funds shall be used to provide long-term vocational support services.

SECTION 2. This act becomes effective July 1, 2005.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE June 15, 2005

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Lavender	Nelson Mullins
George Teague	" "
Becky Garnett	NC Therapeutic Recreation Cert. Board
Pamela Wilson	NC Therapeutic Recreation Cert Board
Dorothy Huffman	N.C. Grange, Lewiston N.C.
Elsie Stinebarger	NC Grange, Watauga Co.
Kathy Swing	ARCADIA (N.C. State Grange)
Peggy Mann	NC Grange Watauga County
Mona Moorehead	Raynet Jones
Don McConnaughey	SAS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE June 15, 2005

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paola Ribadeneira	NC Acupuncture Licensing Bd.
Jill Spainhour	NC Acupuncture Licensing Bd.
Marc Cuffee	NC Acupuncture Association
Barbara Barry	NC. Acupuncture Licensing Bd.
Art Britt	NCDOL
John Hoomani	NCDOL
Rodney S. [illegible]	NC acupuncture assoc.
Gilbert Jackson	Safety + Health Review Board
Kenneth Johnson	Kenneth Johnson

Senate Health Care Committee
Wednesday, June 22, 2005, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1301	**Physical Therapy Bd./Competency of Licensees.**	**Representative Allen**
HB 1482	**Smoking in Public Places/Local Health/DSS.**	**Representative Pierce**
HB 1507	**Amend Interpreter/Transliterator License Act.**	**Representative Alexander**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

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

Wednesday, June 22, 2005

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

FAVORABLE

H.B.(CS #1) **1482** Smoking in Public Places/Local Health/DSS.
Sequential Referral: None
Recommended Referral: None

H.B. **1507** Amend Interpreter/Transliterator License Act.
Sequential Referral: None
Recommended Referral: Finance

TOTAL REPORTED: 2

Committee Clerk Comments:

Senate Health Care Committee
Wednesday, June 22, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 22, 2005, in Room 544 of the Legislative Office Building, with eleven members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator William R. Purcell, Co-Chairs, welcomed the committee members present, introduced the pages, and welcomed Dr. Clark Gaither from Goldsboro.

Representative Alexander was recognized to present HB 1507, ***Amend Interpreter/Transliterator License Act.*** Representative Alexander stated the bill would amend the Interpreter/Transliterator License Act, which was enacted in 2003. The interpreters referred to in HB 1507 are for the deaf and hard of hearing. The bill exempts from the licensing requirements, nationally certificated interpreter/transliterators, who provide services in NC for no more than twenty days per year. There are a lot of conferences that take place in NC and this will enable nationally certified interpreters to come in and help with the conferences. It is hoped that this will increase the number of conferences held in NC. The bill authorizes additional persons to obtain a provisional license. It authorizes the Board to conduct administrative hearings and to assess civil penalties not to exceed one thousand dollars. Senator Forrester asked about line 13 on page one, the definition of nonresident persons. He wanted to know if illegal aliens are nonresident and included in this definition. Ben Popkins, Staff Attorney stated that if illegal aliens are nationally certified they would be qualified but he said that he would check to see if there are any exclusions in the definition of nonresident persons. Senator Dorsett asked who would monitor to determine whether an interpreter performs a service for more than twenty days. Representative Alexander stated it would be up to the Board. Senator Malone asked why the maximum penalty was so high, being one thousand dollars. Representative Alexander responded it was to ensure that the interpretation is correct. Senator Dannley asked what is the penalty now. Staff Attorney Sara Kamprath answered there is none. Senator Dorsett moved for a favorable report, and Senator Bingham stated that staff requested a referral to Finance. The bill passed.

Representative Allen was called on to present, HB 1301, ***Physical Therapy Bd./Competency of Licensees***. Representative Allen explained that the bill allows the NC Board of Physical Therapy Examiners to require evidence of continuing education experiences. Section two of the bill authorizes the Board to decline a license renewal if the licensee fails to make the required showing. It will improve the practice of physical therapy in NC. Senator Hartsell asked how this compares to similar licensures in adjoining states. William Potter, NC Physical Therapy Association, stated the board of Physical Therapy Examiners does not exercise any lobbying function and asked the Association to get this bill introduced and to support it. After a lot of discussion it was decided this bill should be held until next week.

Representative Pierce was recognized to present HB 1482, ***Smoking in Public Places/Local Health/DSS***. Representative Pierce stated the bill allows the Department of Social Services to ban smoking in their department. The Local Health Departments already have this ban on smoking. Senator Dorsett asked if there are multiple sights does it band smoking at all sights. Staff Attorney, Ben Popkins, stated the bill allows the landowner to determine the smoking ban. It only applies to the local department of social services and the grounds around it, that being fifty feet. Senator Dorsett asked why not include Mental Health. Staff Attorney, Ben Popkins, stated that mental health facilities do not have one unified agency. Senator Hartsell moved for a favorable report. The bill passed.

The meeting adjourned at 11:44 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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1301

Committee Substitute Favorable 5/17/05

Short Title: Physical Therapy Bd./Competency of Licensees. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHYSICAL THERAPY EXAMINERS TO REQUIRE LICENSEES TO DEMONSTRATE CONTINUING COMPETENCE IN THE PRACTICE OF PHYSICAL THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.26 is amended by adding the following new subdivision to read:

"**§ 90-270.26. Powers of the Board.**

The Board shall have the following general powers and duties:

...

(3a) Establish mechanisms for assessing the continuing competence of licensed physical therapists or physical therapist assistants to engage in the practice of physical therapy, including approving rules requiring licensees to periodically, or in response to complaints or incident reports, submit to the Board: (i) evidence of continuing education experiences; (ii) evidence of minimum standard accomplishments; or (iii) evidence of compliance with other Board-approved measures, audits, or evaluations; and specify remedial actions if necessary or desirable to obtain license renewal or reinstatement;

...."

SECTION 2. G.S. 90-270.32 reads as rewritten:

"**§ 90-270.32. Renewal of license; lapse; revival.**

(a) Every licensed physical therapist or physical therapist assistant shall, during the month of January of every year, apply to the Board for a renewal of licensure and pay to the secretary-treasurer the prescribed fee. Licenses that are not so renewed shall automatically lapse. The Board may decline to renew licenses of physical therapists or physical therapist assistants for failure to comply with any required continuing competency measures.

(b) The manner in which lapsed licenses shall be ~~revived~~ revived, reinstated, or extended shall be established by the Board in its discretion."

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

HOUSE BILL 1301:
Physical Therapy Bd./Competency of Licensees

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 21, 2005
Introduced by:	Rep. L. Allen	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 1301 would authorize the North Carolina Board of Physical Therapy Examiners to require, as part of the license renewal process, continuing education experiences, minimum standard accomplishments, or compliance with other measures periodically or in response to complaints or incident reports.

CURRENT LAW: Article 18B of Chapter 90 in the General Statutes regulates the practice of Physical Therapy in North Carolina. The North Carolina Board of Physical Therapy Examiners is the enabling body designated to safeguard public health, safety and welfare against unqualified or incompetent practitioners.[1] Under current law, every licensed physical therapist or physical therapist assistant must annually, during the month of January, apply to the Board for a renewal of licensure and must also pay the appropriate established fee.[2]

BILL ANALYSIS: House Bill 1301 authorizes the Board of Physical Therapy Examiners to approve rules establishing mechanisms for assessing the continuing competences of licensed physical therapist and licensed physical therapist assistants. The bill further authorizes the Board to require periodically, or in response to complaints or incident reports, licensees to submit evidence of:

- Continuing education experiences.
- Minimum standard accomplishments.
- Compliance with other Board-approved measures, audits or evaluations.

The Board may decline to renew licenses for failure to comply with any required continuing competency measures.

EFFECTIVE DATE: The act would become effective when it becomes law.

BACKGROUND: The North Carolina Board of Physical Therapy Examiners was created in 1951 by the General Assembly to establish and maintain minimum standards for the practice of physical therapy to protect the safety and welfare of the citizens of North Carolina; to license physical therapists and physical therapist assistants to practice physical therapy in the State; to investigate complaints regarding unauthorized practice of physical therapy in the State and acts of licensees that violate the Practice Act and to issue interpretation of questions arising from the Physical Therapy Practice Act.[3]

H1301e2-SMSQ

[1] G.S. 90-270.26
[2] G.S. 90-270.32
[3] Source- http://www.ncptboard.org

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1482

Committee Substitute Favorable 5/31/05

Short Title: Smoking in Public Places/Local Health/DSS. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO EXEMPT FROM THE LAW GOVERNING SMOKING RESTRICTIONS LOCAL DEPARTMENTS OF SOCIAL SERVICES AND THE BUILDINGS AND GROUNDS WHERE THEY ARE LOCATED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-599, as amended by S.L. 2005-19, reads as rewritten:

"**§ 143-599. Exemptions.**

All of the following facilities shall be exempt from the provisions of this Article:

(1) Any primary or secondary school or child care center, except for a teacher's lounge.

(2) An enclosed elevator.

(3) Public school bus.

(4) Hospital, nursing home, rest home, and State facility operated under the authority of G.S. 122C-181.

(5) Local health ~~department and the building and grounds where the local health department is located.~~department and local department of social services and the building and grounds where the local health department or local department of social services, as applicable, is located. For the purposes of this subdivision, "grounds" means the area located within 50 linear feet of a local health ~~department.~~ department or a local department of social services.

(6) Any nonprofit organization or corporation whose primary purpose is to discourage the use of tobacco products by the general public.

(7) Tobacco manufacturing, processing, and administrative facilities."

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

HOUSE BILL 1482:
Smoking in Public Places/Local Health/DSS

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 22, 2005
Introduced by:	Rep. Pierce	**Summary by:**	Ben Popkin
Version:	Second Edition		Committee Counsel

SUMMARY: House Bill 1482 would exempt local departments of social services and the buildings and grounds of the local departments of social services from current laws governing smoking restrictions. This act would allow local departments to ban smoking from the department itself, the building in which they are located and the entirety of their grounds. The act would define "grounds" as the area "located within 50 linear feet of ... a local department of social services".

CURRENT LAW: Article 64 of the General Statutes addresses the needs and concerns of both smokers and nonsmokers in public places by providing for designated smoking and nonsmoking areas[1]. A list of buildings owned, leased or occupied by state government which may be designated as nonsmoking areas is set forth, including: museums, libraries, UNC health services facilities. Nonsmoking areas must be visibly posted as such, and requirements for separate ventilation systems and physical barriers between nonsmoking and adjacent smoking areas are provided for in the statute[2].

Violation by continuing to smoke in a nonsmoking area after having been given notice to stop smoking is an infraction punishable by a fine of not more than $25.00[3]. Local ordinances, laws or rules passed on or after October 15, 1993 regulating smoking may not contain restrictions exceeding those of Article 64 and may only address smoking in specifically identified types of facilities[4]. An itemized list of facilities is specifically exempted from regulation by the provisions of Article 64 and includes the following: any primary or secondary school, child care center (teacher's lounge excepted), enclosed elevators, public school buses, hospitals, nursing homes, rest homes, local health departments, organizations intended to discourage tobacco use, and tobacco manufacturing, processing and administrative facilities[5].

BILL ANALYSIS: This bill would clarify and expand the coverage of the exemption in G.S. 143-599(5). Recent legislation expanded the exemption from just the premises of a local health department, to include the entire building and grounds where a local health department is located[6]. This bill would add local departments of social services to G.S. 143-599(5) and would apply to the local department of social services building and grounds, as is the case with local health departments. The effect of this bill would be that in situations where the health department shares a building with another organization or entity, the entire building and grounds would be able to be designated as nonsmoking, if the appropriate agency or person in charge would like to give it that designation. For the purposes of G.S. 143-599, "grounds" means the area located within 50 linear feet of a local health department or a local department of social services

EFFECTIVE DATE: This act would be effective when it becomes law.

H1482e2-SMRD

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[1] G.S. 143-595.
[2] G.S. 143-597(b) & (c).
[3] G.S. 143-598.
[4] G.S. 143-601(b).
[5] G.S. 143-599.
[6] S.L. 2005-19.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 1507

Short Title:	Amend Interpreter/Transliterator License Act.	(Public)
Sponsors:	Representative Alexander.	
Referred to:	Finance.	

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO AMEND CERTAIN LAWS UNDER THE NORTH CAROLINA INTERPRETER AND TRANSLITERATOR LICENSURE ACT, TO EXPAND THE GROUP OF PERSONS WHO MAY OBTAIN A PROVISIONAL LICENSE UNDER THE ACT, AND TO AUTHORIZE THE NORTH CAROLINA INTERPRETER AND TRANSLITERATOR LICENSING BOARD TO ASSESS CIVIL PENALTIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90D-4(b) is amended by adding the following new subdivision to read:

"(b) The provisions of this Chapter do not apply to:

...

(6) Nonresident persons who are nationally certified providing interpreting or transliterating services in this State no more than 20 days per year in accordance with rules adopted by the Board."

SECTION 2. G.S. 90D-8 reads as rewritten:

"**§ 90D-8. Provisional license.**

(a) Upon application to the Board and the payment of the required fees, an applicant may be issued a one-time provisional license as an interpreter or transliterator if the applicant meets all of the following qualifications:

(1) Is at least 18 years of age.

(2) Is of good moral character as determined by the Board.

(3) Completes two continuing education units approved by the Board. These units must be completed for each renewable year.

(4) Satisfies one of the following:

a. Holds a quality assurance North Carolina Interpreter Classification System (NCICS) level C classification.

b. Holds a valid National Association of the Deaf (NAD) level 2 or 3 certification.

c. Holds a current Educational Interpreter Performance Assessment (EIPA) level 3 or above classification.

~~d. Holds the following certificates for cued language transliterating coursework: Educational Interpreting Defined, Cued Language Transliterator (CLT) Skill Development I, II, and III, and Ethical Decision Making I.~~

d. Holds at least a two-year interpreting degree from a regionally accredited institution.

(a1) Upon application to the Board, payment of the required fees, and meeting the requirements for a provisional license under subdivisions (1) and (2) of subsection (a) of this section, the Board may also issue a provisional license to any of the following categories of persons seeking a provisional license:

(1) A certified deaf interpreter (CDI) who completes 30 hours of training, including 'Role and Function', 'Code of Ethics', and interpreting professional studies coursework.

(2) An oral interpreter who completes a total of 40 hours of training in interpreting coursework or workshops related to oral interpreting.

(3) A person providing cued speech interpreting or transliterating services who completes a total of 40 hours of training in interpreting coursework or workshops related to cued speech.

(4) A person providing interpreting or transliterating services who has a recognized credential from another state in the field of interpreting or transliterating.

(5) An interpreter or transliterator who has accumulated 200 hours per year in the provision of interpreting or transliterating services, in this State or another state, totaling 400 hours for the two years immediately preceding the date of application.

(b) A provisional license issued under this section shall be valid for one year. Upon expiration, a provisional license may be renewed for an additional one-year period in the discretion of the Board. However, a provisional license shall not be renewed more than three times. The Board may, in its discretion, grant an extension after the third time the provisional license has been renewed under circumstances to be established in rules adopted by the Board.

(c) Effective July 1, 2008, any person who applies for initial licensure on a provisional basis as an interpreter or transliterator shall hold at least a two-year degree from a regionally accredited institution."

SECTION 3. G.S. 90D-6 is amended by adding the following new subdivision to read:

"**§ 90D-6. Powers of the Board.**

The Board shall have the power and duty to:

...

(12) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes."

SECTION 4. Chapter 90D of the General Statutes is amended by adding the following new section to read:

"**§ 90D-14. Civil penalties.**

(a) Authority to Assess Civil Penalties. – The Board may assess a civil penalty not to exceed one thousand dollars ($1,000) for the violation of any section of this Chapter 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, the Board shall 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 Chapter or rules adopted by the Board.

(d) Costs. – The Board may assess the costs of disciplinary actions against a person found to be in violation of this Chapter or rules adopted by the Board."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1507:
Amend Interpreter/Transliterator License Act

BILL ANALYSIS

Committee:	Senate Health	**Date:**	June 22, 2005
Introduced by:	Rep. Alexander	**Summary by:**	Sara Kamprath
Version:	First Edition		Committee Analyst

SUMMARY: House Bill 1507 amends the Interpreters and Transliterators Licensure Act as follows:

- Exempts from licensing requirements nationally certified interpreters or transliterators who provide services in North Carolina for no more than 20 days a year.
- Authorizes additional persons to obtain a provisional license.
- Authorizes Board to conduct administrative hearing in accordance with Chapter 150B
- Authorizes the Board to assess civil penalties not to exceed $1,000 for violations of Chapter 90D.

CURRENT LAW: In 2003, the General Assembly enacted the Interpreter and Transliterator Licensure Act. The purpose of Chapter 90D is to provide for the regulation of persons offering manual or oral interpreting or transliterating services to individuals who are deaf, hard-of-hearing, or dependent on the use of manual modes of communication in this State.

Interpreting is defined as the process of providing accessible communication, between and among persons who are deaf or hard-of-hearing and those who are hearing. This process includes, but is not limited to, communication between American Sign Language and English. It may also involve various other modalities that involve visual, gestural, and tactile methods.

Transliterating is the process of providing accessible communication between one or more hearing persons and one or more deaf or hard-of-hearing persons using a form of manually coded English.

BILL ANALYSIS: Section 1 of the bill adds the following to the list of persons exempt from licensure: "Nonresident persons who are nationally certified providing interpreting or transliterating services in this State no more than 20 days per year in accordance with rules adopted by the Board."

Section 2 of the bill makes the following changes to the statute authorizing a one-year provisional license:

- Deletes a provision authorizing the issuance of a provisional license to persons holding certain course certificates.
- Authorizes the Board to issue a provisional license to a person who is at least 18, of good moral character, and who satisfies one of five listed interpreting or transliterating categories.

Section 3 of the bill authorizes the Board to conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes. Article 3A applies to occupational licensing agencies.

Section 4 of the bill authorizes the Board to assess a civil penalty not to exceed $1,000 for any violation of Chapter 90D or any rules of the Board. Before assessing a civil penalty, the Board must consider four factors. The Board shall also establish a schedule of civil penalties. The Board may assess the costs of disciplinary actions against the person violating the Chapter and rules of the Board.

EFFECTIVE DATE: The bill is effective when it becomes law.

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **June 22, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom VITARELLI	NCCAT
Selena Berrier	Child Fatality Task Force
Dawn Welch	WakeMed
MaryLou Moore	Nurse of the Day
Joanne Stevens	nursing
John Mattox	Gov office
Mildred Spearman	NCDOC
Sherry Pilkington	NCDOC
[illegible]	NCRA
Sheri Copper	Abbott
Darlene Sekerak	NC Physical Therapy Assoc

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **June 22, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
William H. Potter Jr	NCPTA & NCDS
Kathleen Edwards	UNC-CH Legis. Reporting Service
Fred Bone	Bone & Assoc.
Joyce Peters	LP Assoc
Cam Cover	BPMHL
[illegible]	JD, AL, PA
Jo-Ann Coe	NCPA
Marion Smith	GSK
Clark Gaither, M.D.	NC Med. Soc.
Allison Clipp	NCMS
April Culver	JMH

VISITOR REGISTRATION SHEET

Senate Health Care Committee — **June 22, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ANN LOCK	OHHS
Victor Londrey	UNC - Association of Student Governments
Lee Hocker	ICCLHJ
John Bowdish	AstraZeneca
Amy Jo Horne	NCMS
STEVE KEENE	NC MEDICAL SOCIETY
DAVID BARNES	Poyner Spruill
HUGH WILSON	NCHA
Colleen Kochanek	NCCEP

AGENDA

SENATE HEALTH CARE COMMITTEE
February 23, 2005, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

- **HB 1059 Public School Health Curriculum**

III. Other Business

IV. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chai

Wednesday, July 06, 2005

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

FAVORABLE

H.B.(CS #1) **1059** Public School Health Curriculum.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, July 6, 2005
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 6, 2005, in Room 544 of the Legislative Office Building, with thirteen members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. Senator Purcell recognized the Nurse of the Day, Cheryl Batchelor.

Senator Purcell recognized Rep. Thomas Wright to present H.B. 1059, *Public School Heath Curriculum.* He pointed out that this bill updates the school health education program established by G.S. 115C-81(e1) by replacing the term "AIDS" with HIV. Senator Allran noted three additional changes, one a conforming change in language, another delineating the effects of drinking on sexual behavior, and a third dealing with schools' dissemination of information to students. In response to another question, staff replied that there is another change, having to do with other modes of transmission of social diseases besides those through sexual contact. Senator Lucas moved for a favorable report, and the bill passed.

The meeting adjourned at 11:17.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Lorraine R. Blake, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

HOUSE BILL 1059
Committee Substitute Favorable 5/31/05
Third Edition Engrossed 6/1/05

Short Title: Public School Health Curriculum. (Public)

Sponsors:

Referred to:

March 31, 2005

A BILL TO BE ENTITLED

AN ACT TO CORRECT INACCURACIES IN THE USE OF CERTAIN TERMS IN THE GENERAL STATUTES PERTAINING TO THE ADMINISTRATION OF A SCHOOL HEALTH EDUCATION PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 115C-81(e1)(1) reads as rewritten:

"**§ 115C-81. Basic Education Program.**

...

(e1) School Health Education Program to Be Developed and Administered.

(1) A comprehensive school health education program shall be developed and taught to pupils of the public schools of this State from kindergarten through ninth grade. This program includes age-appropriate instruction in the following subject areas, regardless of whether this instruction is described as, or incorporated into a description of, "family life education", "family health education", "health education", "family living", "health", "healthful living curriculum", or "self-esteem":

a. Mental and emotional health;
b. Drug and alcohol abuse prevention;
c. Nutrition;
d. Dental health;
e. Environmental health;
f. Family living;
g. Consumer health;
h. Disease control;
i. Growth and development;
j. First aid and emergency care, including the teaching of cardiopulmonary resuscitation (CPR) and the Heimlich

maneuver by using hands-on training with mannequins so that students become proficient in order to pass a test approved by the American Heart Association, or American Red Cross;

k. Preventing sexually transmitted diseases, including ~~Acquired Immune Deficiency Syndrome (AIDS) virus infection,~~ HIV/AIDS, and other communicable diseases;

l. Abstinence until marriage education; and

m. Bicycle safety.

As used in this subsection, "HIV/AIDS" means Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome."

SECTION 1.(b) G.S. 115C-81(e1)(3), (4), and (5) read as rewritten:

"(3) The State Board of Education shall develop objectives for instruction in the prevention of sexually transmitted diseases, including ~~Acquired Immune Deficiency Syndrome (AIDS) virus infection,~~ HIV/AIDS, that ~~includes~~include emphasis on the importance of parental involvement, abstinence from sex until marriage, and avoiding intravenous drug use. Any program developed under this subdivision shall present techniques and strategies to deal with peer pressure and to offer positive reinforcement and shall teach reasons, skills, and strategies for remaining or becoming abstinent from sexual activity; for appropriate grade levels and classes, shall teach that abstinence from sexual activity until marriage is the only certain means of avoiding out-of-wedlock pregnancy, sexually transmitted ~~diseases,~~ diseases when transmitted through sexual contact, and other associated health and emotional problems, and that a mutually faithful monogamous heterosexual relationship in the context of marriage is the best lifelong means of avoiding diseases transmitted by sexual contact, including ~~Acquired Immune Deficiency Syndrome (AIDS);~~HIV/AIDS, shall teach how alcohol and drug use lower inhibitions, which may lead to risky sexual behavior, and shall teach the positive benefits of abstinence until marriage and the risks of premarital sexual activity. ~~Any instruction concerning the causes of sexually transmitted diseases, including Acquired Immune Deficiency Syndrome (AIDS), in cases where homosexual acts are a significant means of transmission, shall include the current legal status of those acts.~~

(4) The State Board of Education shall evaluate abstinence until marriage curricula and their learning materials and shall develop and maintain a recommended list of one or more approved abstinence until marriage curricula. The State Board may develop an abstinence until marriage program to include on the recommended list. The State Board of Education shall not select or develop a program for inclusion on the recommended list that does not include the positive benefits of abstinence until marriage and the risks of premarital sexual activity as the primary focus. The State Board shall include on the recommended

list only programs that include, in appropriate grades and classes, instruction that:

a. Teaches that abstinence from sexual activity outside of marriage is the expected standard for all school-age children;

b. Presents techniques and strategies to deal with peer pressure and offering positive reinforcement;

c. Presents reasons, skills, and strategies for remaining or becoming abstinent from sexual activity;

d. Teaches that abstinence from sexual activity is the only certain means of avoiding out-of-wedlock pregnancy, sexually transmitted diseases when transmitted through sexual contact, including ~~Acquired Immune Deficiency Syndrome (AIDS),~~ HIV/AIDS, and other associated health and emotional problems;

e. Teaches that a mutually faithful monogamous heterosexual relationship in the context of marriage is the best lifelong means of avoiding sexually transmitted diseases, including ~~Acquired Immune Deficiency Syndrome (AIDS);~~ HIV/AIDS;

f. Teaches the positive benefits of abstinence until marriage and the risks of premarital sexual activity;

g. Provides opportunities that allow for interaction between the parent or legal guardian and the student; ~~and~~

h. Provides factually accurate biological or pathological information that is related to the human reproductive system.

(5) The State Board of Education shall make available to all local school administrative units for review by the parents and legal guardians of students enrolled at that unit any State-developed objectives for instruction, any approved textbooks, the list of reviewed materials, and any other State-developed or approved materials that pertain to or are intended to impart information or promote discussion or understanding in regard to the prevention of sexually transmitted diseases, including ~~Acquired Immune Deficiency Syndrome (AIDS),~~ HIV/AIDS, to the avoidance of out-of-wedlock pregnancy, or to the abstinence until marriage curriculum. The review period shall extend for at least 60 days before use."

SECTION 1.(c) G.S. 115C-81(e1)(7) and (8) read as rewritten:

"(7) Each school year, before students may participate in any portion of (i) a program that pertains to or is intended to impart information or promote discussion or understanding in regard to the prevention of sexually transmitted diseases, including ~~Acquired Immune Deficiency Syndrome (AIDS),~~ HIV/AIDS, or to the avoidance of out-of-wedlock pregnancy, (ii) an abstinence until marriage program, or (iii) a comprehensive sex education program, whether developed by the State or by the local board of education, the parents and legal guardians of

those students shall be given an opportunity to review the objectives and materials. Local boards of education shall adopt policies to provide opportunities either for parents and legal guardians to consent or for parents and legal guardians to withhold their consent to the students' participation in any or all of these programs.

(8) Students may receive information about where to obtain contraceptives and abortion referral services only in accordance with a local board's policy regarding parental consent. Any instruction concerning the use of contraceptives or prophylactics shall provide accurate statistical information on their effectiveness and failure rates for preventing pregnancy and sexually transmitted diseases, including ~~Acquired Immune Deficiency Syndrome (AIDS),~~ HIV/AIDS, in actual use among adolescent populations and shall explain clearly the difference between risk reduction and risk elimination through abstinence. The Department of Health and Human Resources shall provide the most current available information at the beginning of each school year."

SECTION 2. This act is effective when it becomes law and applies beginning with the 2006-2007 school year.

HOUSE BILL 1059:
Public School Health Curriculum

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 5, 2005
Introduced by:	Reps. Wright, B. Allen	**Summary by:**	Sara Kamprath
Version:	Third Edition		Committee Staff

SUMMARY: House Bill 1059 updates the school health education program, established by G.S. 115C-81(e1), by replacing the term AIDS with the term HIV/AIDS. The bill is effective when it becomes law and applies beginning with the 2006-2007 school year.

BILL ANALYSIS: House Bill 1059 replaces all of the references to "Acquired Immune Deficiency Syndrome (AIDS) virus infection" with "HIV/AIDS" throughout the subsection governing the school health education program. The State Board of Education is directed to develop an objective for instruction in the prevention of sexually transmitted diseases that teaches how alcohol and drug use lower inhibitions, which might lead to risky sexual behavior. At the beginning of each school year, the Department of Health and Human Services shall provide the most current information about the effectiveness and failure rates of contraceptives or prophylactics in preventing pregnancy and sexually transmitted diseases.

BACKGROUND: In 1995, the General Assembly enacted legislation that required public schools to offer an abstinence until marriage program and placed certain restrictions on any instruction about sexually transmitted diseases and abstinence until marriage.

H1059e3-SMRJ

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JULY 6, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Josh Kustes	NCFPC
Michele Wallen	NCDPI
Linda Suggs	NCDPI
Jeffrey Walston	DOA 4410
Daniel L. Blue	ACLU of NC
Suzanne Bradley	Gov. Easley's Office
Paiga Johnson	Planned Parenthood
Ian Palmquist	Equality NC
Natalie Fixmer	Planned Parenthood
Paula Wolf	PPHS
BRIAN LEWIS	Covenant w/ NC's Children
Amy Woodell	Guest
Melissa Reed	NARAL

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JULY 6, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	AHCS
[signature]	NCAPC

AGENDA

SENATE HEALTH CARE COMMITTEE
August 10, 2005, at 9:00 A.M.
Room 421, Legislative Office Building

I. Welcome and Opening Remarks

II. Bills to be Considered

• H.B. 1493, An Act Establishing the Pharmacy Quality Assurance Protection Act to Facilitate the Continuous Review of the Practice of Pharmacy	Rep. Cole
• H.B. 613, Update Certification/Licensure/Rec. Therapy	Rep. Harrell, III Rep. Womble
• H.B. 636, Anatomic Pathology Services/Provider Billing	Rep. Nye
• H.B. 1327, Crom. Record Checks/Psychology Practice Act	Rep. Martin, III Rep. Wiley Rep. Harrison
• H.B. 855, Child Nutrition Standards	Rep. Insko

III. Other Business

IV. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE
HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, August 10, 2005

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

FAVORABLE

H.B.(CS #2) **1327** Crim. Record Checks/Psychology Practice Act.
Sequential Referral: None
Recommended Referral: Finance

H.B.(CS #1) **1493** Pharmacy Quality Assurance Protection Act.
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) **613** Update Certification/Licensure/Rec. Therapy.
Draft Number: PCS10391
Sequential Referral: None
Recommended Referral: Finance
Long Title Amended: No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **636** Anatomic Pathology Services/Provider Billing.
Draft Number: PCS60523
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **855** Child Nutrition Standards.
Draft Number: PCS30363
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 5

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

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

CORRECTED REPORT

Wednesday, August 10, 2005

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

FAVORABLE

H.B.(CS #2) **1327** Crim. Record Checks/Psychology Practice Act.

Sequential Referral:	None
Recommended Referral:	Finance

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **613** Update Certification/Licensure/Rec. Therapy.

Draft Number:	PCS10391
Sequential Referral:	None
Recommended Referral:	Finance
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **636** Anatomic Pathology Services/Provider Billing.

Draft Number:	PCS60523
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **855** Child Nutrition Standards.

Draft Number:	PCS30363
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 4

Committee Clerk Comments: Removed HB (C.S.#1) 1493

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, August 10, 2005

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) **1493** Pharmacy Quality Assurance Protection Act.

Draft Number:	PCS70547
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, August 10, 2005
9:00 A.M.
Room 421, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 9:00 A.M. on Wednesday, August 10, 2005, in Room 544 of the Legislative Office Building, with six members present. Senator William R. Purcell presided. Senator Purcell welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell recognized Rep. Nelson Cole to present H.B. 1493, *An Act Establishing the Pharmacy Quality Assurance Protection Act to Facilitate the Continuous Review of the Practice of Pharmacy.* The committee accepted a proposed committee substitute. Senator Malone asked if anyone or any organization had voiced any opposition to this bill. Rep. Cole said he had heard of no opposition. Senator Malone moved for a favorable report, and the committee substitute passed.

Rep. Jim Harrell brought his bill, H.B. 613, *Update Certification/Licensure/Rec. Therapy* to the committee. This bill had been heard by the Senate Health Care Committee on June 13, 2005, and was referred to the Licensing Board. A proposed committee substitute was presented. Senator Garwood moved for a favorable report, and the proposed committee substitute passed, and was referred to the Finance Committee.

Senator Dannelly took the chair so that Senator Purcell could present H.B. 636, *Anatomic Pathology Services/Provider Billing.* A proposed committee substitute was brought forward and passed. Steve Keene of the North Carolina Medical Society and John Bode, representing the pathologists' association both spoke in favor of the bill. Senator Berger moved for a favorable report for the committee substitute and it passed.

Senator Purcell asked Rep. Pricey Harrison to speak on H.B. 1327, *Crim. Record Checks/Psychology Practice Act.* There being no questions or discussion from committee members or the audience, Senator Dannelly moved for a favorable report, and the bill passed.

Senator Bingham presided while Senator Purcell presented H.B. 855, *Child Nutrition Standards*, to the committee. A technical correction was pointed out on page 1, line 13, which corrected a reference to the General Statutes. Senator Garwood moved for a favorable report, with the technical correction in the form of an amendment rolled into a committee substitute.

The meeting adjourned at 9:23 A.M.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Lorraine R. Blake, Committee Assistant

HOUSE BILL 1493:
Pharmacy Quality Assurance Protection Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	August 9, 2005
Introduced by:	Rep. Cole	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 1493 would establish the Pharmacy Quality Assurance Protection Act. The Act would enact a new Article 4B of Chapter 90 of the General Statutes intended to encourage pharmacy quality assurance programs to enhance the quality of health care and reduce medication errors in the State by facilitating a process for the continuous review of the practice of pharmacy.

BILL ANALYSIS: House Bill 1493 would enact a new Article 4B entitled the "Pharmacy Quality Assurance Protection Act". The Act would provide that persons or entities holding valid pharmacy permits would establish or participate in pharmacy quality assurance programs to evaluate the following:

1. Quality of practice of the pharmacy;
2. Cause of medication errors;
3. Pharmaceutical care outcomes;
4. Possible improvements for the practice of pharmacy; and
5. Methods to reduce medication error occurrences.

The Act would define a pharmacy quality assurance program as being either:

- A program of a pharmacy association incorporated under Chapter 55A of the General Statutes that evaluates the quality of pharmacy services and medication errors and makes recommendations to improve quality of pharmacy services; or
- A program established by a person or entity holding a valid pharmacy permit to evaluate the quality of pharmacy services and medication errors and to make recommendations to improve the quality of pharmacy services.
- A quality assurance committee or medical or peer review committee established by a health care provider licensed under this Chapter or a health care facility licensed under Chapters 122C, 131D, or 131E of the General Statutes that include evaluation of quality pharmacy services and medication errors and makes recommendations to improve the quality of pharmacy services.

The Act would set forth provisions addressing liability for performing services other than when doing so as a member of a pharmacy quality assurance program and would include provisions addressing the use of otherwise privileged information for the purposes of participating in the pharmacy quality assurance program and its related procedures.

- The Act sets the provisions on how and when the Board of Pharmacy can request information about an alleged medication incident or error from a pharmacy or pharmacy permittee's designated agent.

EFFECTIVE DATE: The Act would be effective when it becomes law.

H1493e2-SMSQ

Senate Committee Substitute 8/10/05

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H **D**

HOUSE BILL 1493
Committee Substitute Favorable 5/31/05
PROPOSED SENATE COMMITTEE SUBSTITUTE H1493-PCS70547-SQ-44

Short Title: Pharmacy Quality Assurance Protection Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT ESTABLISHING THE PHARMACY QUALITY ASSURANCE PROTECTION ACT TO FACILITATE THE CONTINUOUS REVIEW OF THE PRACTICE OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.21(a) reads as rewritten:

"(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacy personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in pharmacy personnel within 30 days of the change. In addition to identifying the pharmacist-manager, a pharmacy may identify a pharmacy permittee's designated agent that the Board shall notify of any investigation of the pharmacy or a pharmacist employed by the pharmacy within 48 hours of the Board initiating an investigation. The notice shall include the specific reason for the investigation."

SECTION 2. G.S. 90-85.26 reads as rewritten:

"**§ 90-85.26. Prescription orders preserved.**

(a) Every pharmacist-manager of a pharmacy shall maintain for at least three years the original of every prescription order and refill compounded or dispensed at the pharmacy except for prescription orders recorded in a patient's medical record. An automated data processing system may be used for the storage and retrieval of refill information for prescriptions pursuant to the regulations of the Board.

(b) Every pharmacy permittee's designated agent shall maintain documentation of alleged medication errors and incidents described in G.S. 90-85.47(e)(1) for which the pharmacy permittee has knowledge."

SECTION 3. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"Article 4B.

"Pharmacy Quality Assurance Protection Act.

"**§ 90-85.45. Legislative intent.**

It is the intent of the General Assembly to require pharmacy quality assurance programs to further contribute to and enhance the quality of health care and reduce medication errors in this State by facilitating a process for the continuous review of the practice of pharmacy.

"**§ 90-85.46. Definitions.**

The following definitions shall apply in this Article:

(1) Board. – The North Carolina Board of Pharmacy.

(2) Pharmacy quality assurance program. – A program pertaining to one of the following:

a. A pharmacy association created under G.S. 90-85.4 or incorporated under Chapter 55A of the General Statutes that evaluates the quality of pharmacy services and alleged medication errors and incidents and makes recommendations to improve the quality of pharmacy services.

b. A program established by a person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21(a) to evaluate the quality of pharmacy services and alleged medication errors and incidents and make recommendations to improve the quality of pharmacy services.

c. A quality assurance committee or medical or peer review committee established by a health care provider licensed under this Chapter or a health care facility licensed under Chapter 122C, 131D, or 131E of the General Statutes that includes evaluation of the quality of pharmacy services and alleged medication errors and incidents and makes recommendations to improve the quality of pharmacy services.

"**§ 90-85.47. Pharmacy quality assurance program required; limited liability; discovery.**

(a) Every person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21(a), shall establish or participate in a pharmacy quality assurance program as defined under G.S. 90-85.46(2), to evaluate the following:

(1) The quality of the practice of pharmacy.

(2) The cause of alleged medication errors and incidents.

(3) Pharmaceutical care outcomes.

(4) Possible improvements for the practice of pharmacy.

(5) Methods to reduce alleged medication errors and incidents.

(b) There shall be no monetary liability on the part of, or no cause of action for damages arising against, any member of a duly appointed pharmacy quality assurance program or any pharmacy or pharmacist furnishing information to a pharmacy quality assurance program or any person, including a person acting as a witness or incident reporter to or investigator for a pharmacy quality assurance program, for any act or

proceeding undertaken or performed within the scope of the functions of the pharmacy quality assurance program.

(c) This section shall not be construed to confer immunity from liability on any professional association, pharmacy or pharmacist, or health care provider while performing services other than as a member of a pharmacy quality assurance program or upon any person, including a person acting as a witness or incident reporter to or investigator for a pharmacy quality assurance program, for any act or proceeding undertaken or performed outside the scope of the functions of the pharmacy quality assurance program. Except as provided in subsection (a) or (b) of this section, where a cause of action would arise against a pharmacy, pharmacist, or an individual health care provider, the cause of action shall remain in effect.

(d) The proceedings of a pharmacy quality assurance program, 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 or G.S. 58-2-100 and shall not be subject to discovery or introduction into evidence in any civil action, administrative hearing or Board investigation against a pharmacy, pharmacist, pharmacy technician, a pharmacist manager or a permittee 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, administrative hearing or Board Investigation results from matters that are the subject of evaluation and review by the pharmacy quality assurance program. No person who was in attendance at a meeting of the pharmacy quality assurance program shall be required to testify in any civil action, administrative hearing or Board investigation as to any evidence or other matters produced or presented during the proceedings of the pharmacy quality assurance program or as to any findings, recommendations, evaluations, opinions, or other actions of the pharmacy quality assurance program 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 pharmacy quality assurance program. 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 pharmacy quality assurance program. A member of the pharmacy quality assurance program may testify in a civil or administrative action but cannot be asked about the person's testimony before the pharmacy quality assurance program or any opinions formed as a result of the pharmacy quality assurance program. Nothing in this subsection shall preclude:

(1) A pharmacy, pharmacist, pharmacy technician, or other person or any agent or representative of a pharmacy, pharmacist, pharmacy technician or other person participating on a pharmacy quality assurance program may use otherwise privileged, confidential information for legitimate internal business or professional purposes of the pharmacy quality assurance program.

(2) A pharmacy, pharmacist, pharmacy technician, other person participating on the committee, or any person or organization named as a defendant in a civil action, a respondent in an administrative

proceeding, or a pharmacy, pharmacist, or pharmacy technician subject to a Board investigation as a result of participation in the pharmacy quality assurance program may use otherwise privileged, confidential information in the pharmacy quality assurance program or person's own defense. A plaintiff in the civil action or the agency in the administrative proceeding may disclose records or determinations of or communications to the pharmacy quality assurance program in rebuttal to information given by the defendant, respondent, or pharmacist subject to Board investigation.

(e) Upon the Board providing written notice to the pharmacy permittee's designated agent under G.S. 90-85.21(a) and pharmacist of an investigation against the pharmacist, including the specific reason for the Board investigation, the pharmacy permittee's designated agent shall compile and provide documentation within 10 days of the receipt of the notice of any alleged medication error or incident committed by the pharmacist in the 12 months preceding the receipt of the notice, that the pharmacy permittee has knowledge of, when:

(1) The alleged medication error or incident resulted in any of the following:

a. An emergency room visit attributed to the alleged medication incident or error.

b. Hospitalization requiring an overnight stay or longer.

c. A fatality.

(2) The pharmacist is the subject of disciplinary action conducted under Article 3A of Chapter 150B of the General Statutes. Unless the documentation relates to an alleged medication error or incident that was specifically the cause of the investigation, the Board may review the documentation only after the Board has made findings of fact and conclusions of law pursuant to G.S. 150B-42(a) and may use the documentation in determining the remedial action the pharmacist shall undergo as part of the disciplinary action imposed by the Board. The documentation shall be released only to the Board or its designated employees pursuant to this subsection and shall not otherwise be released except as required by law.

Any information provided to the Board pursuant to this subsection shall be returned to the pharmacy permittee's designated agent within 10 days after the Board has made findings of fact and conclusions of law pursuant to G.S. 150B-42(a).

The documentation provided to the Board shall not include the proceedings and records of a pharmacy quality assurance program or information prepared by the pharmacy solely for consideration by or upon request of a pharmacy quality assurance program.

(f) Nothing in this section shall preclude the Board from obtaining information concerning a specific alleged medication error or incident that is the subject of a Board investigation resulting from a complaint to the Board."

SECTION 4. This act becomes effective January 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1493

Committee Substitute Favorable 5/31/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H1493-CSRU-75 [v.2]

7/25/2005 6:51:59 PM

Short Title: Pharmacy Quality Assurance Protection Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT ESTABLISHING THE PHARMACY QUALITY ASSURANCE PROTECTION ACT TO FACILITATE THE CONTINUOUS REVIEW OF THE PRACTICE OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.21(a) reads as rewritten:

"(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacy personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in pharmacy personnel within 30 days of the change. In addition to identifying the pharmacist-manager, a pharmacy may identify a pharmacy permittee's designated agent that the Board shall notify of any investigation of the pharmacy or a pharmacist employed by the pharmacy within forty-eight hours of the Board initiating an investigation. The notice shall include the specific reason for the investigation."

SECTION 2. G.S. 90-85.26 reads as rewritten:

"**§ 90-85.26. Prescription orders preserved.**

(a) Every pharmacist-manager of a pharmacy shall maintain for at least three years the original of every prescription order and refill compounded or dispensed at the pharmacy except for prescription orders recorded in a patient's medical record. An automated data processing system may be used for the storage and retrieval of refill information for prescriptions pursuant to the regulations of the Board.

(b) Every pharmacy permittee's designated agent shall maintain documentation of alleged medication errors and incidents described in G.S. 90-85.47(e)(1) for which the pharmacy permittee has knowledge."

SECTION 3. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"Article 4B.

"Pharmacy Quality Assurance Protection Act.

"**§ 90-85.45. Legislative intent.**

It is the intent of the General Assembly to require pharmacy quality assurance programs to further contribute to and enhance the quality of health care and reduce medication errors in this State by facilitating a process for the continuous review of the practice of pharmacy.

"**§ 90-85.46. Definitions.**

The following definitions shall apply in this Article:

(1) Board. – The North Carolina Board of Pharmacy.

(2) Pharmacy quality assurance program. – A program pertaining to one of the following:

a. A pharmacy association created under G.S. 90-85.4 or incorporated under Chapter 55A of the General Statutes that evaluates the quality of pharmacy services and alleged medication errors and incidents, and makes recommendations to improve the quality of pharmacy services.

b. A program established by a person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A to evaluate the quality of pharmacy services and alleged medication errors and incidents, and make recommendations to improve the quality of pharmacy services.

c. A quality assurance committee or medical or peer review committee established by a health care provider licensed under this Chapter or a health care facility licensed under Chapters 122C, 131D, or 131E of the General Statutes that includes evaluation of the quality of pharmacy services and alleged medication errors and incidents, and makes recommendations to improve the quality of pharmacy services.

"**§ 90-85.47. Pharmacy quality assurance program required; limited liability; discovery.**

(a) Every person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A, shall establish or participate in a pharmacy quality assurance program as defined under G.S. 90-85.46(2), to evaluate the following:

(1) The quality of the practice of pharmacy.

(2) The cause of alleged medication errors and incidents.

(3) Pharmaceutical care outcomes.

(4) Possible improvements for the practice of pharmacy.

(5) Methods to reduce alleged medication error and incidents.

(b) There shall be no monetary liability on the part of, or no cause of action for damages arising against, any member of a duly appointed pharmacy quality assurance program or any pharmacy or pharmacist furnishing information to a pharmacy quality assurance program or any person, including a person acting as a witness or incident reporter to or investigator for a pharmacy quality assurance program, for any act or

proceeding undertaken or performed within the scope of the functions of the pharmacy quality assurance program.

(c) This section shall not be construed to confer immunity from liability on any professional association, pharmacy or pharmacist, or health care provider while performing services other than as a member of a pharmacy quality assurance program or upon any person, including a person acting as a witness or incident reporter to or investigator for a pharmacy quality assurance program, for any act or proceeding undertaken or performed outside the scope of the functions of the pharmacy quality assurance program. Except as provided in subsection (a) or (b) of this section, where a cause of action would arise against a pharmacy, pharmacist, or an individual health care provider, the cause of action shall remain in effect.

(d) The proceedings of a pharmacy quality assurance program, 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 or G.S. 58-2-100, and shall not be subject to discovery or introduction into evidence in any civil action, administrative hearing or Board investigation against a pharmacy, pharmacist, pharmacy technician, a pharmacist manager or a permittee 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, administrative hearing or Board Investigation results from matters that are the subject of evaluation and review by the pharmacy quality assurance program. No person who was in attendance at a meeting of the pharmacy quality assurance program shall be required to testify in any civil action, administrative hearing or Board investigation as to any evidence or other matters produced or presented during the proceedings of the pharmacy quality assurance program or as to any findings, recommendations, evaluations, opinions, or other actions of the pharmacy quality assurance program 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 pharmacy quality assurance program. 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 pharmacy quality assurance program. A member of the pharmacy quality assurance program may testify in a civil or administrative action but cannot be asked about the person's testimony before the pharmacy quality assurance program or any opinions formed as a result of the pharmacy quality assurance program. Nothing in this subsection shall preclude:

(1) A pharmacy, pharmacist, pharmacy technician, or other person or any agent or representative of a pharmacy, pharmacist, pharmacy technician or other person participating on a pharmacy quality assurance program may use otherwise privileged, confidential information for legitimate internal business or professional purposes of the pharmacy quality assurance program.

(2) A pharmacy, pharmacist, pharmacy technician, other person participating on the committee, or any person or organization named as a defendant in a civil action, a respondent in an administrative

proceeding, or a pharmacy, pharmacist or pharmacy technician subject to a Board investigation as a result of participation in the pharmacy quality assurance program may use otherwise privileged, confidential information in the pharmacy quality assurance program or person's own defense. A plaintiff in the civil action or the agency in the administrative proceeding may disclose records or determinations of or communications to the pharmacy quality assurance program in rebuttal to information given by the defendant, respondent, or pharmacist subject to Board investigation.

(e) Upon the Board providing written notice to the pharmacy permittee's designated agent under G.S. 90-21(a) and pharmacist of an investigation against the pharmacist, including the specific reason for the Board investigation, the pharmacy permittee's designated agent shall compile and provide documentation within 10 days of the receipt of the notice of any alleged medication error or incident committed by the pharmacist in the 12 months preceding the receipt of the notice, that the pharmacy permittee has knowledge of, when:

(1) The alleged medication error or incident resulted in any of the following:

a. An emergency room visit attributed to the alleged medication incident or error.

b. Hospitalization requiring an overnight stay or longer.

c. A fatality.

(2) The pharmacist is the subject of disciplinary action conducted under Article 3A of Chapter 150B of the General Statutes. Unless the documentation relates to an alleged medication error or incident that was specifically the cause of the investigation, the Board may review the documentation only after the Board has made findings of fact and conclusions of law pursuant to G.S. 150B-42(a) and may use the documentation in determining the remedial action the pharmacist shall undergo as part of the disciplinary action imposed by the Board. The documentation shall be released only to the Board or its designated employees pursuant to this subsection and shall not otherwise be released except as required by law.

Any information provided to the Board pursuant to this subsection shall be returned to the pharmacy permittee's designated agent within 10 days after the Board has made findings of fact and conclusions of law pursuant to G.S. 150B-42(a).

The documentation provided to the Board shall not include the proceedings and records of a pharmacy quality assurance program or information prepared by the pharmacy solely for consideration by or upon request of a pharmacy quality assurance program.

(f) Nothing in this section shall preclude the Board from obtaining information concerning a specific alleged medication error or incident that is the subject of a Board investigation resulting from a complaint to the Board."

SECTION 4. This act becomes effective October 1, 2005. Section 3 of this act shall supersede all administrative rules regulating the maintenance of alleged medication error or incident records in effect as of October 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1493

Committee Substitute Favorable 5/31/05

Short Title: Pharmacy Quality Assurance Protection Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT ESTABLISHING THE PHARMACY QUALITY ASSURANCE PROTECTION ACT TO FACILITATE THE CONTINUOUS REVIEW OF THE PRACTICE OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.21(a) reads as rewritten:

"(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacy personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in pharmacy personnel within 30 days of the change. In addition to identifying the pharmacist-manager, a pharmacy may identify a pharmacy permittee's designated agent that the Board shall notify of any investigation of the pharmacy or a pharmacist employed by the pharmacy. The notice shall include the specific reason for the investigation."

SECTION 2. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"Article 4B.

"Pharmacy Quality Assurance Protection Act.

"**§ 90-85.45. Legislative intent.**

It is the intent of the General Assembly to encourage pharmacy quality assurance programs to further contribute to and enhance the quality of health care and reduce medication errors in this State by facilitating a process for the continuous review of the practice of pharmacy.

"**§ 90-85.46. Definitions.**

The following definitions shall apply in this Article:

(1) Board. – The North Carolina Board of Pharmacy.

(2) Pharmacy quality assurance program. – A program pertaining to one of the following:

a. A pharmacy association created under G.S. 90-85.4 and incorporated under Chapter 55A of the General Statutes that evaluates the quality of pharmacy services and medication errors and makes recommendations to improve the quality of pharmacy services.

b. A program established by a person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A to evaluate the quality of pharmacy services and medication errors and make recommendations to improve the quality of pharmacy services.

c. A quality assurance committee or medical or peer review committee established by a health care provider licensed under this Chapter or a health care facility licensed under Chapters 122C, 131D, or 131E of the General Statutes that includes evaluation of the quality of pharmacy services and medication errors and makes recommendations to improve the quality of pharmacy services.

"**§ 90-85.47. Pharmacy quality assurance program required; limited liability; discovery.**

(a) Every person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A, shall establish or participate in a pharmacy quality assurance program as defined under G.S. 90-85.46(2), to evaluate the following:

(1) The quality of the practice of pharmacy.

(2) The cause of medication errors.

(3) Pharmaceutical care outcomes.

(4) Possible improvements for the practice of pharmacy.

(5) Methods to reduce medication error occurrences.

(b) There shall be no monetary liability on the part of, or no cause of action for damages arising against, any member of a duly appointed pharmacy quality assurance program or any pharmacy or pharmacist furnishing information to a pharmacy quality assurance program or any person, including a person acting as a witness or incident reporter to or investigator for a pharmacy quality assurance program, for any act or proceeding undertaken or performed within the scope of the functions of the pharmacy quality assurance program.

(c) This section shall not be construed to confer immunity from liability on any professional association, pharmacy or pharmacist, or health care provider while performing services other than as a member of a pharmacy quality assurance program or upon any person, including a person acting as a witness or incident reporter to or investigator for a pharmacy quality assurance program, for any act or proceeding undertaken or performed outside the scope of the functions of the pharmacy quality assurance program. Except as provided in subsection (a) or (b) of this section, where a cause of action would arise against a pharmacy, pharmacist, or an individual health care provider, the cause of action shall remain in effect.

(d) Except as provided in this subsection, the proceedings and records of a pharmacy quality assurance program shall not be subject to discovery or be introduced into evidence in any civil action, administrative proceeding, or investigation arising out of matters that are the subject of evaluation and review by the pharmacy quality assurance program; nor shall any person in attendance at a meeting of a pharmacy quality assurance program be permitted or required to testify in any civil action, administrative hearing or Board investigation as to any evidence or other matters produced or presented during the proceedings of the pharmacy quality assurance program regarding any findings, recommendations, evaluations, opinions, or other actions of a pharmacy quality assurance program or any members of the program. However, the information, documents, or records otherwise available from original sources shall not be construed as prohibited from discovery for use in any civil action merely because they were presented during proceedings of a pharmacy quality assurance program; nor shall any person testifying before a pharmacy quality assurance program or member of a pharmacy quality assurance program be prevented from testifying as to matters within the person's or member's knowledge; provided that, the witness shall not be asked about his or her testimony before a pharmacy quality assurance program or opinions formed by the witness as a result of the pharmacy quality assurance program. Confidential information may be used under the following circumstances:

(1) A pharmacy, pharmacist, or other person or any agent or representative of a pharmacy, pharmacist, or other person participating on a pharmacy quality assurance program may use otherwise privileged, confidential information for legitimate internal business or professional purposes of the pharmacy quality assurance program.

(2) A pharmacy, pharmacist, other person participating on the committee, or any person or organization named as a defendant in a civil action, a respondent in an administrative proceeding, or a pharmacist subject to a Board investigation as a result of participation in the pharmacy quality assurance program may use otherwise privileged, confidential information in the pharmacy quality assurance program or person's own defense. A plaintiff in the civil action or the agency in the administrative proceeding may disclose records or determinations of or communications to the pharmacy quality assurance program in rebuttal to information given by the defendant, respondent, or pharmacist subject to Board investigation.

(e) Upon the Board providing written notice to the pharmacy permittee's designated agent under G.S. 90-21(a) and pharmacist of an investigation against the pharmacist, including the specific reason for the Board investigation, the pharmacy permittee's designated agent shall compile and provide documentation within 10 days of the receipt of the notice of any alleged medication incident or error committed by the pharmacist in the 12 months preceding the receipt of the notice, that the pharmacy permittee has knowledge of, when:

(1) The alleged medication error or incident resulted in: (i) an emergency room visit attributed to the alleged medication incident or error; (ii) hospitalization requiring an overnight stay or longer; or (iii) fatality.

(2) The pharmacist is the subject of disciplinary action conducted under Article 3A of Chapter 150B of the General Statutes. Unless the documentation relates to an alleged medication incident or error that was specifically the cause of the investigation, the Board may review the documentation only after the Board has made findings of fact and conclusions of law pursuant to G.S. 150B-42(a) and may use the documentation in determining the remedial action the pharmacist shall undergo as part of the disciplinary action imposed by the Board. The documentation shall be released only to the Board or its designated employees pursuant to this subsection and shall not otherwise be released except as required by law.

Any information provided to the Board pursuant to this subsection shall be returned to the pharmacy permittee's designated agent within 10 days after the Board has made findings of fact and conclusions of law pursuant to G.S. 150B-42(a).

The documentation provided to the Board shall not include the proceedings and records of a pharmacy quality assurance program or information prepared by the pharmacy solely for consideration by or upon request of a pharmacy quality assurance program."

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

HOUSE BILL 613:
Update Certification/Licensure/Rec. Therapy

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 15, 2005
Introduced by:	Reps. Harrell, Womble	**Summary by:**	Shawn Parker
Version:	Second Edition		Committee Staff

SUMMARY: House Bill 613 updates the laws regulating the practice of recreational therapy. The bill increases the maximum licensure application from $50 to $200 and the maximum renewal fee from $25 to $200. The bill deletes a $25 reinstatement fee and a $10 certificate replacement fee and adds a new maximum record maintenance fee of $100 and an inactive fee of $50.

BILL ANALYSIS: House Bill 613 rewrites Chapter 90C of the General Statutes as follows:

- Changes the name of the Chapter from "Therapeutic Recreation Personnel Certification Act" to "North Carolina Recreational Therapy Licensure Act.
- Changes certification to licensure and changes the titles of licensees. The current law authorizes certification as a therapeutic recreation specialist or a therapeutic recreation assistant. HB 613 authorizes the licensure of a recreational therapist and licensed recreational therapy assistant and defines a recreational therapy aide as a non-licensed person who aids in providing recreational therapy services under the direct supervision of a licensed recreational therapist or licensed recreational therapy assistant.
- Adds an additional member to the current seven-member Board. The new member shall be appointed by the Governor and must be a physician licensed in North Carolina.
- Gives the Board a power to:
  - Issue annually a list of persons currently licensed under the Chapter.
  - Establish or approve competency requirements for licensure, including examinations and continuing education.
- Sets out the requirements for licensure as a recreational therapist or recreational therapy assistant. Any current State-certified person working in the scope of recreational therapy before January 30, 2006, is exempt from all educational, examination, and experience requirements for initial licensure under the Chapter if the person applies to the Board for licensure before January 15, 2008. The applicant must also be working within the scope of recreational therapy and previously certified by the Board at the time of application.
- Amends the maximum fees of the Board as follows:

Current Maximum Fees		Proposed Maximum Fees	
Certification as a therapeutic recreation specialist or as a therapeutic recreation assistant	$50	Initial licensure	$200
		Licensure renewal fee	$200
Certificate renewal	$25	Record maintenance fee	$100
Reinstatement of lapsed or expired certificate	$25	Inactive fee	$ 50
Replacement certificate	$10		

- Provides that the Chapter does not apply to incidental work by person licensed in another profession, federal employees, or students pursuing a degree in recreational therapy and fulfilling supervised fieldwork requirements.
- Makes it a Class 1 misdemeanor with a maximum fine of $500 for a person not licensed under the Chapter to represent himself or herself as licensed or to practice recreational therapy or therapeutic recreation. Current law provides for a maximum fine of $500 and/or imprisonment not to exceed 60 days.

EFFECTIVE DATE: October 1, 2005

Martha Walston contributed significantly to this analysis.

H0613e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 613

Committee Substitute Favorable 5/18/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H613-PCS10391-SQ-40

Short Title: Update Certification/Licensure/Rec. Therapy. (Public)

Sponsors:

Referred to:

March 14, 2005

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS REGULATING THE PRACTICE OF RECREATIONAL THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90C-1 through G.S. 90C-19 are repealed.

SECTION 1.1. The title of Chapter 90C reads as rewritten:

"**Chapter 90C.**

~~**Therapeutic Recreation Personnel Certification Act.**~~ **North Carolina Recreational Therapy Licensure Act.**"

SECTION 2. Chapter 90C of the General Statutes is amended by adding the following new sections to read:

"**§ 90C-20. Short title.**

This Chapter shall be known as the 'North Carolina Recreational Therapy Licensure Act'.

"**§ 90C-21. Purpose.**

It is the purpose and intent of the Recreational Therapy Licensure Act to safeguard the health and safety of the public and to protect the public from harm by unqualified persons by establishing a minimum level of education, experience, and competence to assure the highest degree of professional care and conduct on the part of licensed recreational therapists and licensed recreational therapy assistants.

"**§ 90C-22. Definitions.**

In this Chapter, unless the context otherwise requires, the following definitions shall apply:

(1) Board. – The North Carolina Board of Recreational Therapy Licensure.

(2) Licensed recreational therapist. – A person who holds a license pursuant to this Chapter as a recreational therapist. A person licensed

as a 'Recreational Therapist' under this Chapter may practice in clinical, residential, educational, and community settings and may:

a. Conduct an individualized patient or client assessment for the purpose of collecting systematic, comprehensive, and accurate data necessary to determine a course of action and subsequent individualized treatment plan.

b. Plan and develop the individualized treatment plan that identifies a patient or client's goals, objectives, and treatment intervention strategies.

c. Implement the individualized treatment plan that is consistent with the overall patient or client treatment program.

d. Systematically evaluate and compare the patient or client's response to the individualized treatment plan and suggest modifications as appropriate.

e. Develop a discharge plan in collaboration with the patient or client, his or her family, and other treatment team members.

f. Serve as a resource for patient or client recreation opportunities to promote or improve his or her general health and well-being.

g. Deliver services in accordance with the professional standards of practice and codes of ethics promulgated by national or State professional organizations.

h. Manage delivery of services in accordance with a written plan of operation based upon standards advanced by appropriate membership, regulatory, and credentialing agencies.

i. Provide professional and preprofessional education and training of recreational therapists or recreational therapy assistants.

j. Conduct research in the field of recreational therapy or therapeutic recreation.

(3) Licensed recreational therapy assistant. – A person who holds a license pursuant to this Chapter as a recreational therapy assistant to act under the supervision of a licensed recreational therapist as defined by rule. A person licensed as a 'Recreational Therapy Assistant' under this Chapter may assist in the practice of recreational therapy in clinical, residential, and community settings under the supervision of a licensed recreational therapist and in accordance with a recreational therapy assistant's training, education, and scope of practice, as defined by rule.

(4) Person. – Any individual, corporation, partnership, association, unit of government, or other legal entity.

(5) Recreational therapy aide. – Any nonlicensed person who aids in the provision of recreational therapy services under the provisions of this Chapter, and who acts under the direction and on-site supervision of a licensed recreational therapist or licensed recreational therapy assistant. A recreational therapy aide may perform recreational therapy

related duties and functions which are assigned and are commensurate with an aide's training and competency. An aide's work shall not include responding to a physician's orders; designing, conducting, or interpreting individualized recreational therapy patient assessment; determining or modifying recreational therapy treatment plans or interventions; or any independent practice or performance of recreational therapy services.

(6) Scope of recreational therapy. – The practice of recreational therapy includes all direct patient or client services of assessment, planning, design, implementation, evaluation, and documentation of specific interventions, management, consultation, research, and education for either individuals or groups that require specific therapeutic recreation or recreational therapy intervention representing the process and knowledge base delineated in the most recent National Council for Therapeutic Recreation Certification (NCTRC) Job Analysis Study and professional standards of practice. Scope is inclusive of professional and preprofessional education and training in recreational therapy, therapeutic recreation, and related research.

(7) Recreational therapy. – A treatment service designed to restore, remediate, or rehabilitate a patient or client's level of functioning and independence in life activities, as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

(8) Therapeutic recreation. – The provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purposes of treatment services, which are often referred to as recreational therapy, are to restore, remediate, or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purposes of recreation services are to provide recreation resources and opportunities in order to improve health and well-being. Therapeutic recreation is provided by professionals who are trained and certified, registered, or licensed to provided therapeutic recreation.

"**§ 90C-23. North Carolina Recreational Therapy Licensure Board is created.**

(a) The North Carolina Recreational Therapy Licensure Board is created.

(b) Composition. – The Board shall consist of eight members appointed as follows:

(1) Three practicing recreational therapists, one of whom shall be appointed by the Governor, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

(2) One licensed practicing recreational therapy assistant appointed by the Governor.
(3) One licensed practicing recreational therapist who is engaged primarily in providing education or training for recreational therapists or recreational therapy assistants appointed by the Governor.
(4) One physician licensed pursuant to Article 1 of Chapter 90 of the General Statutes appointed by the Governor.
(5) Two public members, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

The Governor shall make appointments after consultation with the North Carolina Recreational Therapy Licensure Board and other interested persons.

(c) Qualifications. – The nonpublic recreational therapist or recreational therapy assistant members of the Board shall hold a current license. Each nonpublic recreational therapist or recreational therapy assistant member of the Board, at the time of his or her appointment and for at least two years before, shall have been actively engaged in North Carolina in the practice of recreational therapy or therapeutic recreation, in the education and training of graduate or undergraduate students of recreational therapy or therapeutic recreation, or in recreational therapy or therapeutic recreation research.

One public member shall not be a licensed health care professional or an agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. One public member shall have received recreational therapy or therapeutic recreation services. For purposes of this subsection, a person enrolled in a program to prepare him or her to be a licensed health care professional or an allied health professional shall not be eligible to serve as a public member of the Board. The spouse of any person who would be prohibited by this subsection from serving on the Board as a public member shall not serve as a public member of the Board. Public members shall reasonably reflect the population of this State.

(d) Term. – Members of the Board shall serve three-year staggered terms and shall serve until a successor is appointed and qualified. No member shall serve more than two consecutive full terms.

(e) Vacancies. – The Governor shall fill vacancies to the Board positions for which the Governor is the appointing authority within 30 days after a position is vacated. The General Assembly shall fill vacancies for which it is the appointing authority in accordance with G.S. 120-122. Appointees shall serve the remainder of the unexpired term and until their successors have been appointed and qualified.

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

(g) Compensation. – Each member of the Board shall receive such per diem compensation and reimbursement for travel and subsistence as shall be set for licensing Board members generally, as provided in G.S. 93B-5.

(h) Officers. – The officers of the Board shall be a chairman, a vice-chairman, and other officers deemed necessary by the Board to carry out the purposes of this Chapter. All officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(i) Meetings. – The Board shall hold at least two meetings each year to conduct business and shall adopt rules governing the calling, holding, and conducting of regular and special meetings. A majority of the Board members shall constitute a quorum.

(j) Employees. – The Board may employ necessary personnel for the performance of its functions and fix their compensation within the limits of the funds available to the Board.

(k) The total expense of the administration of this Chapter shall not exceed the total income from fees collected pursuant to this Chapter. None of the expenses of the Board, or the compensation or expenses of any officer or any employee of the Board, shall be paid or payable out of the General Fund. Neither the Board nor any of its officers or employees may incur any expense, debt, or other financial obligation binding upon the State.

"**§ 90C-24. Powers of the Board.**

(a) The Board shall have the following general powers and duties:

(1) To administer this Chapter.

(2) To issue interpretations of this Chapter.

(3) To adopt, amend, or repeal rules and regulations in the manner prescribed by Chapter 150B of the General Statutes, as may be necessary to carry out the provisions of this Chapter.

(4) To establish qualifications of, employ, and set the compensation of the Executive Director who shall not be a member of the Board.

(5) To employ and fix the compensation of the personnel that the Board determines are necessary to carry out the provisions of this Chapter and to incur other expenses necessary to effectuate this Chapter.

(6) To determine the qualifications of persons who are licensed pursuant to this Chapter.

(7) To issue, renew, deny, suspend, or revoke licenses and carry out any of the other actions authorized by this Chapter.

(8) To conduct investigations for the purpose of determining whether violations of this Chapter are grounds for revoking, denying, suspending, or refusing to renew the licenses of persons licensed pursuant to this Chapter.

(9) To maintain a record of all proceedings and make available to persons who hold a license and other concerned parties an annual report of all Board action.

(10) To set fees for licensure, license renewal, and other services deemed necessary to carry out the purpose of this Chapter.

(11) To adopt a seal containing the name of the Board to be used on licenses and official reports it issues.

(12) To issue annually a list stating the names of persons currently licensed under the privilege of this Chapter.

(13) To establish or approve, as defined by rule, reasonable competency requirements for licensure, including the power to adopt or use examination materials, study or training courses, and standards of recognized accrediting and credentialing agencies and professional associations and the power to establish or approve, as defined by rule, reasonable standards for renewal of licensure, including requirements for continuing recreational therapy or therapeutic recreation education.

(b) The powers and duties enumerated above are granted for the purpose of enabling the Board to protect the public from misrepresentation of licensure status as provided in this Chapter and shall be liberally construed to accomplish this objective.

"**§ 90C-25. Executive Director.**

The Executive Director shall deposit all fees payable to the Board in financial institutions designated by the Board as official depositories. The funds shall be deposited in the name of the Board and shall be used to pay all expenses incurred by the Board in carrying out the purposes of this Chapter. The State Auditor shall audit the Board annually.

"**§ 90C-26. The Board may accept contributions, etc.**

The Board may accept grants, contributions, devises, bequests, and gifts that shall be kept in a separate fund and shall be used by it to publicize the licensure program and its protective benefits to the public.

"**§ 90C-27. Requirements for licensure.**

(a) The Board shall license any person as a 'Licensed Recreational Therapist' who meets the following education, credential, and experience requirements:

(1) Passage of an appropriate examination as a therapeutic recreation specialist or a recreational therapist by the North Carolina Recreational Therapy Licensure Board or current certification as a 'Certified Therapeutic Recreation Specialist' by the National Council for Therapeutic Recreation Certification.

(2) A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations.

(3) For purposes of this subsection, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having a bachelors or masters degree with a specialization in recreational therapy or therapeutic recreation.

(b) The Board shall license any person as a 'Licensed Recreational Therapy Assistant' who meets the following education and experience requirements:

(1) A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations as deemed appropriate by the Board.

(2) For purposes of this section, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having associate degree curricula in recreational therapy or therapeutic recreation.

"**§ 90C-28. Licensure fees.**

Applications for licensure shall be made on forms prescribed and furnished by the Board. The Board may establish fees for the actual cost of duplication services, materials, and returned bank items. All fees derived from services provided by the Board under the provisions of this Chapter shall be nonrefundable. The Board shall establish the amount of fees as defined by rule not to exceed the following amounts:

(1)	Initial application for licensure fee	$200.00
(2)	Licensure renewal fee	$200.00
(3)	Record maintenance fee	$100.00
(4)	Inactive fee	$ 50.00.

"**§ 90C-29. License renewal.**

Every license issued pursuant to this Chapter shall be renewable every two years. Within 30 days before the expiration date, a person who desires to continue to be licensed in the field of therapeutic recreation or recreational therapy shall apply for license renewal on forms furnished by the Board. The applicant shall meet criteria for renewal, including continuing education, established by the Board as defined by rule and shall pay the required fee established by the Board pursuant to this Chapter. Failure to renew the license before the expiration date shall result in automatic forfeiture of any license issued pursuant to this Chapter.

The Executive Director shall notify, in writing, every person at his or her last known address of the expiration of his or her license and the amount that is required for its two-year renewal.

"**§ 90C-30. Reinstatement.**

A person who has allowed his or her license to lapse by failure to renew it pursuant to this Chapter must apply for licensure on a reinstatement form provided by the Board. The Board shall require the applicant to return the completed reinstatement licensure form including renewal requirements established by the Board as defined by rule. If the license has lapsed for more than two years, the Board shall require the applicant to successfully demonstrate competency as defined by rules established by the Board. If the Board determines that the license should be reinstated, it shall issue a license renewal to the applicant.

"**§ 90C-31. Inactive list.**

When a person licensed by the Board submits a request for inactive status and pays the inactive fee, the Board shall issue to the person a statement of inactive status and shall place the person's name on the 'Inactive Status' list. While on that list, the person

shall not hold himself or herself out as licensed pursuant to this Chapter. When that person desires to be removed from the inactive list and returned to an active list, an application shall be submitted to the Board on a form furnished by the Board, and the fee shall be paid for license renewal. The Board shall require evidence of competency as defined by rule to resume practice before returning the applicant to the active status.

"**§ 90C-32. Revocation, suspension, or denial of licensure.**

The Board may require remedial education, issue of a letter of reprimand, restrict, revoke, or suspend any license issued pursuant to this Chapter or deny any application for licensure if the Board determines that the licensee or applicant has done any of the following:

(1) Given false information or withheld material information from the Board in procuring or attempting to procure a license pursuant to this Chapter.

(2) Been convicted of, or pleaded guilty or nolo contendere to, any crime that indicates that the person is unfit or incompetent to be licensed pursuant to this Chapter.

(3) Is unable to perform the functions for which a license has been issued due to impairment of mental or physical faculties.

(4) Engaged in conduct that endangers the public health.

(5) Is unfit or incompetent to be licensed pursuant to this Chapter by reason of deliberate or negligent acts or omissions regardless of whether active injury to the patient or client is established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of claiming licensed status or practicing recreational therapy.

(7) Willfully violated any provision of this Chapter, rules, or code of ethics enacted by the Board.

(8) Aided, abetted, or assisted any person in violating the provisions of this Chapter.

The Board may reinstate a revoked license or remove licensure restrictions when it finds that the reasons for revocation or restriction no longer exist and that the person can reasonably be expected to safely and properly practice recreational therapy.

"**§ 90C-33. Reciprocity.**

The Board may grant a license, without examination or by special examination, to any person who, at the time of application, is licensed as a recreational therapist or therapeutic recreation specialist by a similar Board of another country, state, or territory whose licensing standards are substantially equivalent to or higher than those required by this Chapter. The Board shall determine the substantial equivalence upon which reciprocity is based.

"**§ 90C-34. Persons and practices not affected.**

Nothing in this Chapter shall be construed to prevent or restrict:

(1) Any person qualified, registered, certified, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, or licensed to engage in another profession or occupation in this State from performing work

incidental to the practice of that profession or occupation as long as that person does not represent himself or herself as a recreational therapy assistant or recreational therapist or the work to be recreational therapy or therapeutic recreation as defined by this Chapter.

(2) Any person employed as a therapeutic recreation specialist, therapeutic recreation assistant, or recreational therapist or a recreational therapy assistant by the government of the United States, if he or she provides therapeutic recreation or recreational therapy solely under the direction and control of the organization by which he or she is employed.

(3) Any person pursuing a course of study leading to a degree in recreational therapy or therapeutic recreation at an accredited college or university that meets the minimum academic requirements for a major or specialization in recreational therapy as defined by the rules and regulations of the Board.

(4) Any person fulfilling the supervised fieldwork experience required for a degree and for licensure, as defined by the rules of the Board, if the person is designated by a title that clearly indicates his or her status as a student.

"**§ 90C-35. Reports; immunity from suit.**

Any person who has reasonable cause to suspect malpractice, misconduct, or incapacity of a person who is licensed pursuant to this Chapter or who has reasonable cause to suspect that any person is in violation of this Chapter should report the relevant facts to the Board. Upon receipt of a charge or upon its own initiative, the Board may give notice of an administrative hearing pursuant to Chapter 150B of the General Statutes or may, after diligent investigation, dismiss unfounded charges. Any person making a report pursuant to this section shall be immune from criminal prosecution or civil liability based on that report unless the person knew the report was false or acted in reckless disregard of whether or not the report was false.

"**§ 90C-36. Violations and penalties.**

Any person not licensed under this Chapter who holds himself or herself out to be licensed under this Chapter or who practices recreational therapy or therapeutic recreation shall be guilty of a Class 1 misdemeanor. Any fine imposed as a result of conviction shall not exceed five hundred dollars ($500.00).

"**§ 90C-37. Enjoining illegal practices.**

(a) If the Board finds that a person is violating any of the provisions of this Chapter, it may apply in its own name to the superior court for a temporary or permanent restraining order or an injunction to prevent that person from continuing the illegal practices. The court is empowered to grant an injunction regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation. All actions by the Board shall be governed by the Rules of Civil Procedure.

(b) The venue for actions brought under this Chapter shall be in the county where the defendant resides or the county where the violation occurs."

SECTION 3. Members serving on the North Carolina State Board of Therapeutic Recreation Certification on the effective date of this act shall continue to

serve and complete their current terms on the North Carolina Recreational Therapy Licensure Board established in G.S. 90C-23, as enacted in Section 2 of this act. The Governor shall appoint the physician member to serve a three-year term pursuant to G.S. 90C-23(b)(4), as enacted in Section 2 of this act. Members appointed thereafter shall serve three-year staggered terms.

SECTION 4. Any current State-certified person working within the scope of recreational therapy, as defined in G.S. 90C-22(7), as enacted in Section 2 of this act, as a recreational therapist or a recreational therapy assistant before January 30, 2006, may be exempt from all educational, examination, and experience requirements for initial licensure pursuant to this Chapter, as enacted in Section 2 of this act. In order to qualify for this exemption, an applicant must apply to the Board for licensure before January 15, 2008, and the applicant must be working within the scope of recreational therapy and previously certified by the Board at the time of application. The Board shall attempt in good faith to notify all current State-certified persons of the availability of this exemption and the deadlines for qualifying and applying for licensure under this act.

SECTION 5. This act becomes effective October 5, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 613
Committee Substitute Favorable 5/18/05

Short Title: Update Certification/Licensure/Rec. Therapy. (Public)

Sponsors:

Referred to:

March 14, 2005

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LAWS REGULATING THE PRACTICE OF RECREATIONAL THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90C-1 through G.S. 90C-19 are repealed.

SECTION 1.1. The title of Chapter 90C reads as rewritten:

"**Chapter 90C.**

~~**Therapeutic Recreation Personnel Certification Act.**~~ **North Carolina Recreational Therapy Licensure Act.**"

SECTION 2. Chapter 90C of the General Statutes is amended by adding the following new sections to read:

"**§ 90C-20. Short title.**

This Chapter shall be known as the 'North Carolina Recreational Therapy Licensure Act'.

"**§ 90C-21. Purpose.**

It is the purpose and intent of the Recreational Therapy Licensure Act to safeguard the health and safety of the public and to protect the public from harm by unqualified persons by establishing a minimum level of education, experience, and competence to assure the highest degree of professional care and conduct on the part of licensed recreational therapists and licensed recreational therapy assistants.

"**§ 90C-22. Definitions.**

In this Chapter, unless the context otherwise requires, the following definitions shall apply:

(1) Board. – The North Carolina Board of Recreational Therapy Licensure.

(2) Licensed recreational therapist. – A person who holds a license pursuant to this Chapter as a recreational therapist. A person licensed as a 'Recreational Therapist' under this Chapter may practice in clinical, residential, educational, and community settings and may:

a. Conduct an individualized patient or client assessment for the purpose of collecting systematic, comprehensive, and accurate data necessary to determine a course of action and subsequent individualized treatment plan.

b. Plan and develop the individualized treatment plan that identifies a patient or client's goals, objectives, and treatment intervention strategies.

c. Implement the individualized treatment plan that is consistent with the overall patient or client treatment program.

d. Systematically evaluate and compare the patient or client's response to the individualized treatment plan and suggest modifications as appropriate.

e. Develop a discharge plan in collaboration with the patient or client, his or her family, and other treatment team members.

f. Serve as a resource for patient or client recreation opportunities to promote or improve his or her general health and well-being..

g. Deliver services in accordance with the professional standards of practice and codes of ethics promulgated by national or State professional organizations.

h. Manage delivery of services in accordance with a written plan of operation based upon standards advanced by appropriate membership, regulatory, and credentialing agencies.

i. Provide professional and preprofessional education and training of recreational therapists or recreational therapy assistants.

j. Conduct research in the field of recreational therapy or therapeutic recreation.

(3) Licensed recreational therapy assistant. – A person who holds a license pursuant to this Chapter as a recreational therapy assistant to act under the supervision of a licensed recreational therapist as defined by rule. A person licensed as a 'Recreational Therapy Assistant' under this Chapter may assist in the practice of recreational therapy in clinical, residential, and community settings under the supervision of a licensed recreational therapist and in accordance with a recreational therapy assistant's training, education, and scope of practice, as defined by rule.

(4) Person. – Any individual, corporation, partnership, association, unit of government, or other legal entity.

(5) Recreational therapy aide. – Any nonlicensed person who aids in the provision of recreational therapy services under the provisions of this Chapter, and who, acts under the direction and on-site supervision of a licensed recreational therapist or licensed recreational therapy assistant. A recreational therapy aide may perform recreational therapy related duties and functions which are assigned and are commensurate with an aide's training and competency. An aide's work shall not

include responding to a physician's orders; designing, conducting, or interpreting individualized recreational therapy patient assessment; determining or modifying recreational therapy treatment plans or interventions; or any independent practice or performance of recreational therapy services.

(6) Scope of recreational therapy. – The practice of recreational therapy includes all direct patient or client services of assessment, planning, design, implementation, evaluation, and documentation of specific interventions, management, consultation, research, and education for either individuals or groups that require specific therapeutic recreation or recreational therapy intervention representing the process and knowledge base delineated in the most recent National Council for Therapeutic Recreation Certification (NCTRC) Job Analysis Study and professional standards of practice. Scope is inclusive of professional and preprofessional education and training in recreational therapy, therapeutic recreation, and related research.

(7) Recreational therapy. – A treatment service designed to restore, remediate, or rehabilitate a patient or client's level of functioning and independence in life activities, as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

(8) Therapeutic recreation. – The provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purposes of treatment services, which are often referred to as recreational therapy, are to restore, remediate, or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purposes of recreation services are to provide recreation resources and opportunities in order to improve health and well-being. Therapeutic recreation is provided by professionals who are trained and certified, registered, or licensed to provided therapeutic recreation.

"**§ 90C-23. North Carolina Recreational Therapy Licensure Board is created.**

(a) The North Carolina Recreational Therapy Licensure Board is created.

(b) Composition. – The Board shall consist of eight members appointed as follows:

(1) Three practicing recreational therapists, one of whom shall be appointed by the Governor, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore, and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

(2) One licensed practicing recreational therapy assistant appointed by the Governor.

(3) One licensed practicing recreational therapist who is engaged primarily in providing education or training for recreational therapists or recreational therapy assistants appointed by the Governor.

(4) One physician licensed pursuant to Article 1 of Chapter 90 of the General Statutes appointed by the Governor.

(5) Two public members, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

The Governor shall make appointments after consultation with the North Carolina Recreational Therapy Licensure Board and other interested persons.

(c) Qualifications. – The nonpublic recreational therapist or recreational therapy assistant members of the Board shall hold a current license. Each nonpublic recreational therapist or recreational therapy assistant member of the Board, at the time of his or her appointment and for at least two years before, shall have been actively engaged in North Carolina in the practice of recreational therapy or therapeutic recreation, in the education and training of graduate or undergraduate students of recreational therapy or therapeutic recreation, or in recreational therapy or therapeutic recreation research.

One public member shall not be a licensed health care professional or an agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. One public member shall have received recreational therapy or therapeutic recreation services. For purposes of this subsection, a person enrolled in a program to prepare him or her to be a licensed health care professional or an allied health professional shall not be eligible to serve as a public member of the Board. The spouse of any person who would be prohibited by this subsection from serving on the Board as a public member shall not serve as a public member of the Board. Public members shall reasonably reflect the population of this State.

(d) Term. – Members of the Board shall serve three-year staggered terms and shall serve until a successor is appointed and qualified. No member shall serve more than two consecutive full terms.

(e) Vacancies. – The Governor shall fill vacancies to the Board positions for which the Governor is the appointing authority within 30 days after a position is vacated. The General Assembly shall fill vacancies for which it is the appointing authority in accordance with G.S. 120-122. Appointees shall serve the remainder of the unexpired term and until their successors have been appointed and qualified.

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

(g) Compensation. – Each member of the Board shall receive such per diem compensation and reimbursement for travel and subsistence as shall be set for licensing Board members generally, as provided in G.S. 93B-5.

(h) Officers. – The officers of the Board shall be a chairman, a vice-chairman, and other officers deemed necessary by the Board to carry out the purposes of this Chapter. All officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(i) Meetings. – The Board shall hold at least two meetings each year to conduct business and shall adopt rules governing the calling, holding, and conducting of regular and special meetings. A majority of the Board members shall constitute a quorum.

(j) Employees. – The Board may employ necessary personnel for the performance of its functions, and fix their compensation, within the limits of the funds available to the Board.

(k) The total expense of the administration of this Chapter shall not exceed the total income from fees collected pursuant to this Chapter. None of the expenses of the Board, or the compensation or expenses of any officer or any employee of the Board, shall be paid or payable out of the General Fund. Neither the Board nor any of its officers or employees may incur any expense, debt, or other financial obligation binding upon the State.

"**§ 90C-24. Powers of the Board.**

(a) The Board shall have the following general powers and duties:

(1) To administer this Chapter.

(2) To issue interpretations of this Chapter.

(3) To adopt, amend, or repeal rules and regulations in the manner prescribed by Chapter 150B of the General Statutes, as may be necessary to carry out the provisions of this Chapter.

(4) To establish qualifications of, employ, and set the compensation of the Executive Director who shall not be a member of the Board.

(5) To employ and fix the compensation of the personnel that the Board determines are necessary to carry out the provisions of this Chapter and to incur other expenses necessary to effectuate this Chapter.

(6) To determine the qualifications of persons who are licensed pursuant to this Chapter.

(7) To issue, renew, deny, suspend, or revoke licenses and carry out any of the other actions authorized by this Chapter.

(8) To conduct investigations for the purpose of determining whether violations of this Chapter are grounds for revoking, denying, suspending, or refusing to renew the licenses of persons licensed pursuant to this Chapter.

(9) To maintain a record of all proceedings and make available to persons who hold a license and other concerned parties an annual report of all Board action.

(10) To set fees for licensure, license renewal, and other services deemed necessary to carry out the purpose of this Chapter.

(11) To adopt a seal containing the name of the Board to be used on licenses and official reports it issues.

(12) To issue annually a list stating the names of persons currently licensed under the privilege of this Chapter.

(13) To establish or approve, as defined by rule, reasonable competency requirements for licensure, including the power to adopt or use examination materials, study or training courses, and standards of recognized accrediting and credentialing agencies and professional associations and the power to establish or approve, as defined by rule, reasonable standards for renewal of licensure, including requirements for continuing recreational therapy or therapeutic recreation education.

(b) The powers and duties enumerated above are granted for the purpose of enabling the Board to protect the public from misrepresentation of licensure status as provided in this Chapter and shall be liberally construed to accomplish this objective.

"**§ 90C-25. Executive Director.**

The Executive Director shall deposit all fees payable to the Board in financial institutions designated by the Board as official depositories. The funds shall be deposited in the name of the Board and shall be used to pay all expenses incurred by the Board in carrying out the purposes of this Chapter. The State Auditor shall audit the Board annually.

"**§ 90C-26. The Board may accept contributions, etc.**

The Board may accept grants, contributions, devises, bequests, and gifts that shall be kept in a separate fund and shall be used by it to publicize the licensure program and its protective benefits to the public.

"**§ 90C-27. Requirements for licensure.**

(a) The Board shall license any person as a 'Licensed Recreational Therapist' who meets the following education, credential, and experience requirements:

(1) Passage of an appropriate examination as a therapeutic recreation specialist or a recreational therapist by the North Carolina Recreational Therapy Licensure Board or current certification as a 'Certified Therapeutic Recreation Specialist' by the National Council for Therapeutic Recreation Certification.

(2) A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations.

(3) For purposes of this subsection, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having a bachelors or masters degree with a specialization in recreational therapy or therapeutic recreation.

(b) The Board shall license any person as a 'Licensed Recreational Therapy Assistant' who meets the following education and experience requirements:

(1) A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines

promulgated by professional associations and credentialing and accrediting organizations as deemed appropriate by the Board.

(2) For purposes of this section, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having associate degree curricula in recreational therapy or therapeutic recreation.

"**§ 90C-28. Licensure fees.**

Applications for licensure shall be made on forms prescribed and furnished by the Board. The Board may establish fees for the actual cost of duplication services, materials, and returned bank items. All fees derived from services provided by the Board under the provisions of this Chapter shall be nonrefundable. The Board shall establish the amount of fees as defined by rule not to exceed the following amounts:

(1)	Initial application for licensure fee	$200.00
(2)	Licensure renewal fee	$200.00
(3)	Record maintenance fee	$100.00
(4)	Inactive fee	$ 50.00.

"**§ 90C-29. License renewal.**

Every license issued pursuant to this Chapter shall be renewable every two years. Within 30 days before the expiration date, a person who desires to continue to be licensed in the field of therapeutic recreation or recreational therapy shall apply for license renewal on forms furnished by the Board. The applicant shall meet criteria for renewal, including continuing education, established by the Board as defined by rule and shall pay the required fee established by the Board pursuant to this Chapter. Failure to renew the license before the expiration date shall result in automatic forfeiture of any license issued pursuant to this Chapter.

The Executive Director shall notify, in writing, every person at his or her last known address of the expiration of his or her license and the amount that is required for its two-year renewal.

"**§ 90C-30. Reinstatement.**

A person who has allowed his or her license to lapse by failure to renew it pursuant to this Chapter must apply for licensure on a reinstatement form provided by the Board. The Board shall require the applicant to return the completed reinstatement licensure form including renewal requirements established by the Board as defined by rule. If the license has lapsed for more than two years, the Board shall require the applicant to successfully demonstrate competency as defined by rules established by the Board. If the Board determines that the license should be reinstated, it shall issue a license renewal to the applicant.

"**§ 90C-31. Inactive list.**

When a person licensed by the Board submits a request for inactive status and pays the inactive fee, the Board shall issue to the person a statement of inactive status and shall place the person's name on the 'Inactive Status' list. While on that list, the person shall not hold himself or herself out as licensed pursuant to this Chapter. When that person desires to be removed from the inactive list and returned to an active list, an

application shall be submitted to the Board on a form furnished by the Board, and the fee shall be paid for license renewal. The Board shall require evidence of competency as defined by rule to resume practice before returning the applicant to the active status.

"**§ 90C-32. Revocation, suspension, or denial of licensure.**

The Board may require remedial education, issue of a letter of reprimand, restrict, revoke, or suspend any license issued pursuant to this Chapter or deny any application for licensure if the Board determines that the licensee or applicant has done any of the following:

(1) Given false information or has withheld material information from the Board in procuring or attempting to procure a license pursuant to this Chapter.

(2) Been convicted of, or pleaded guilty or nolo contendere to, any crime that indicates that the person is unfit or incompetent to be licensed pursuant to this Chapter.

(3) Is unable to perform the functions for which a license has been issued due to impairment of mental or physical faculties.

(4) Engaged in conduct that endangers the public health.

(5) Is unfit or incompetent to be licensed pursuant to this Chapter by reason of deliberate or negligent acts or omissions regardless of whether active injury to the patient or client is established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of claiming licensed status or practicing recreational therapy.

(7) Willfully violated any provision of this Chapter, rules, or code of ethics enacted by the Board.

(8) Aided, abetted, or assisted any person in violating the provisions of this Chapter.

The Board may reinstate a revoked license or remove licensure restrictions when it finds that the reasons for revocation or restriction no longer exist and that the person can reasonably be expected to safely and properly practice recreational therapy.

"**§ 90C-33. Reciprocity.**

The Board may grant a license, without examination or by special examination, to any person who, at the time of application, is licensed as a recreational therapist or therapeutic recreation specialist by a similar Board of another country, state, or territory whose licensing standards are substantially equivalent to or higher than those required by this Chapter. The Board shall determine the substantial equivalence upon which reciprocity is based.

"**§ 90C-34. Persons and practices not affected.**

Nothing in this Chapter shall be construed to prevent or restrict:

(1) Any person qualified, registered, certified, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, or licensed to engage in another profession or occupation in this State from performing work incidental to the practice of that profession or occupation as long as that person does not represent himself or herself as a recreational

therapy assistant or recreational therapist or the work to be recreational therapy or therapeutic recreation as defined by this Chapter.

(2) Any person employed as a therapeutic recreation specialist, therapeutic recreation assistant, or recreational therapist or a recreational therapy assistant by the government of the United States, if he or she provides therapeutic recreation or recreational therapy solely under the direction and control of the organization by which he or she is employed.

(3) Any person pursuing a course of study leading to a degree in recreational therapy or therapeutic recreation at an accredited college or university that meets the minimum academic requirements for a major or specialization in recreational therapy as defined by the rules and regulations of the Board.

(4) Any person fulfilling the supervised fieldwork experience required for a degree and for licensure, as defined by the rules of the Board, if the person is designated by a title that clearly indicates his or her status as a student.

"**§ 90C-35. Reports; immunity from suit.**

Any person who has reasonable cause to suspect malpractice, misconduct, or incapacity of a person who is licensed pursuant to this Chapter or who has reasonable cause to suspect that any person is in violation of this Chapter should report the relevant facts to the Board. Upon receipt of a charge or upon its own initiative, the Board may give notice of an administrative hearing pursuant to Chapter 150B of the General Statutes or may, after diligent investigation, dismiss unfounded charges. Any person making a report pursuant to this section shall be immune from criminal prosecution or civil liability based on that report unless the person knew the report was false or acted in reckless disregard of whether or not the report was false.

"**§ 90C-36. Violations and penalties.**

Any person not licensed under this Chapter who holds himself or herself out to be licensed under this Chapter or who practices recreational therapy or therapeutic recreation shall be guilty of a Class 1 misdemeanor. Any fine imposed as a result of conviction shall not exceed five hundred dollars ($500.00).

"**§ 90C-37. Enjoining illegal practices.**

(a) If the Board finds that a person is violating any of the provisions of this Chapter, it may apply in its own name to the superior court for a temporary or permanent restraining order or an injunction to prevent that person from continuing the illegal practices. The court is empowered to grant an injunction regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation. All actions by the Board shall be governed by the Rules of Civil Procedure.

(b) The venue for actions brought under this Chapter shall be in the county where the defendant resides or the county where the violation occurs."

SECTION 3. Members serving on the North Carolina State Board of Therapeutic Recreation Certification on the effective date of this act shall continue to serve and complete their current terms on the North Carolina Recreational Therapy Licensure Board established in G.S. 90C-23, as enacted in Section 2 of this act. The

Governor shall appoint the physician member to serve a three-year term pursuant to G.S. 90C-23(b)(4), as enacted in Section 2 of this act. Members appointed thereafter shall serve three-year staggered terms.

SECTION 4. Any current State-certified person working within the scope of recreational therapy, as defined in G.S. 90C-22(7), as enacted in Section 2 of this act, as a recreational therapist or a recreational therapy assistant before January 30, 2006, may be exempt from all educational, examination, and experience requirements for initial licensure pursuant to this Chapter, as enacted in Section 2 of this act. In order to qualify for this exemption, an applicant must apply to the Board for licensure before January 15, 2008, and the applicant must be working within the scope of recreational therapy and previously certified by the Board at the time of application. The Board shall attempt in good faith to notify all current State-certified persons of the availability of this exemption and the deadlines for qualifying and applying for licensure under this act.

SECTION 5. This act becomes effective October 1, 2005.

HOUSE BILL 636:
Anatomic Pathology Services/Provider Billing

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	August 10, 2005
Introduced by:	Rep. Nye	**Summary by:**	Shawn Parker
Version:	PCS to 2nd Edition		Committee Analyst

SUMMARY: ***House Bill 636 requires disclosure of markups of anatomic pathology services by physicians, hospitals, dentists, and podiatrist. The bill directs the Division of Facility services of DHHS and State licensing boards subject to G.S. 90-681 to report to the General Assembly on the efforts made to apprise and evaluate licensed practitioners and licensed health care facilities of the requirements of this act.***

The Senate committee substitute increases the penalty for an out of state practitioner not licensed and registered in this State practicing surgery or medicine in this State to a Class I felony.

BILL ANALYSIS: House Bill 636 creates a new article in Chapter 90 of the North Carolina General Statutes. Article 40 (Pathology Services Billing) establishes a requirement of disclosure for markups of anatomical pathological services by physicians, hospitals, dentists, and podiatrists.

Section 1 (a, b) makes it unlawful for any person licensed to practice medicine, podiatry, or dentistry, or any hospital licensed in this State to bill for anatomic pathology services in an amount excessive of what the clinical laboratory performing the service charged unless it is conspicuously disclosed on the itemized bill or statement, or in writing by a separate itemized disclosure statement which includes the following:

- The amount charged by the laboratory.
- Any other charge that has been included in the bill.
- The name of the licensed practitioner performing or supervising the service.

Subsection (c) requires the bills for anatomical pathology services must disclose the name and address of the laboratory performing the service.

Subsection (d) provides an exception to the provisions of subsections (a) and (b) to licensed practitioners performing or supervising the services and to a hospital or physician group practice where a physician employee under contract is providing or supervising the services.

Subsection (e) defines anatomic pathology services as used in the section.

Subsection (f) clarifies that terms and conditions of contracts for the provision of anatomic pathology services are not required to be disclosed.

Subsection (g) (h) clarify that the provisions of (a) and (b) of this act do not apply to referring laboratories in instances where the sample must be sent for a second opinion, and that nothing in this act prohibits a physician from requesting services from more than one laboratory for a second medical opinion.

Subsection (i) makes it a Class 3 misdemeanor offense punishable by a $250 fine for each intentional failure to disclose in violation of subsection (a), (b), or (c) of this act.

Subsection (j) gives the respective State licensing board authority to take action including suspending, revoking, or denying licensure for violations provided in this act.

Subsection (k) requires within (6) six months of the effective date of this act for the Division of Facility Services to communicate the requirements of this section to all licensed practitioners and licensed facilities subject to this section.

Section 2 amends G.S. 90-18(a) adding a requirement that out of state practitioners without proper North Carolina licensure may be charged with a Class I felony for practicing medicine in this State.

Section 3 directs the Division of Facility Services of the Department of Health and Human Services to report on the efforts made to apprise and evaluate licensed practitioners and licensed health care facilities of the requirements of this act to the 2006 Regular Session of the 2005 General Assembly upon its convening.

EFFECTIVE DATE: The act is effective when it becomes law.

BACKGROUND: According to the National Conference of State Legislatures, currently (8) eight states enforce direct billing requirements for all payers. Eleven states either prohibit or discourage physician mark up on bills for clinical laboratory services.

The policy of "direct billing" where payment is made only to the person or entity that performed or supervised the service is consistent with AMA ethics principles and is a Medicare requirement. The college of American Pathologist supports direct billing requirements and the dissolution of the practice of "client billing" where the treating physician may realize a profit by charging a patient full price for a service the physician received at a discount.

H0636e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 636

Committee Substitute Favorable 5/31/05
Third Edition Engrossed 6/1/05
PROPOSED SENATE COMMITTEE SUBSTITUTE H636-CSSQ-34 [v.5]

8/8/2005 9:15:56 AM

Short Title: Anatomic Pathology Services/Provider Billing. (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE DISCLOSURE OF MARKUPS OF ANATOMIC PATHOLOGY SERVICES BY PHYSICIANS, HOSPITALS, DENTISTS, AND PODIATRISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Pathology Services Billing.

"**§ 90-681. Billing of anatomic pathology services.**

(a) It shall be unlawful for any person licensed to practice medicine, podiatry, or dentistry in this State to bill a patient, entity, or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the licensed practitioner discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement:

(1) The amounts charged by the laboratory for the anatomic pathology service;

(2) Any other charge that has been included in the bill, and

(3) The name of the licensed practitioner performing or supervising the anatomic pathology service.

The disclosure required under this subsection shall be printed in a 10-point or higher font size.

(b) It shall be unlawful for any hospital licensed in this State to bill a patient, entity, or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the hospital

discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement:

(1) The amounts charged by the laboratory for the professional anatomic pathology services;

(2) Any other charge that has been included in the bill, and

(3) The name of the licensed practitioner performing or supervising the anatomic pathology service.

The disclosure required under this subsection shall be printed in a 10-point or higher font size.

(c) A bill for anatomic pathology services submitted to a patient, entity, or person for payment shall disclose the name and address of the laboratory performing the professional component of the service.

(d) The requirements of subsections (a) and (b) of this section shall not apply to:

(1) A licensed practitioner performing or supervising anatomic pathology services, or

(2) A hospital or physician group practice where a physician employee or physician under contract to a hospital or a physician group practice is providing or supervising anatomic pathology services and is compensated by the hospital or physician group practice for the services.

(e) As used in this section, the term "anatomic pathology services" means:

(1) Histopathology or surgical pathology meaning the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician;

(2) Cytopathology meaning the examination of cells from fluids, aspirates, washings, brushings, or smears, including the Pap test examination performed by a physician or under the supervision of a physician;

(3) Hematology meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;

(4) Subcellular pathology and molecular pathology; and

(5) Blood-banking services performed by pathologists.

(f) Nothing in this section shall be construed to require the disclosure of the terms or conditions of a contract for the provision of anatomic pathology services between a managed care organization and a hospital or between a managed care organization and a physician's practice.

(g) The requirements of subsections (a) and (b) of this section shall not apply to a referring laboratory providing anatomic pathology services for services performed by that laboratory in instances where one or more samples must be sent for a second medical opinion on a specimen.

(h) Nothing in this section shall be construed as a prohibition on a physician requesting the anatomic pathology services of more than one clinical laboratory for a second medical opinion on a specimen.

(i) Each intentional failure to disclose in violation of subsections (a), (b), or (c) of this section is a separate Class 3 misdemeanor offense punishable by a fine of two hundred fifty dollars ($250.00).

(j) The respective State licensing boards having jurisdiction over practitioners subject to this section may revoke, suspend, or deny renewal of the license of a practitioner that violates this section. Each State licensing board having jurisdiction may take disciplinary action on a finding by the board of intentional violation or an ongoing pattern of violations in the absence of a misdemeanor conviction.

(k) Not later than six months from the effective date of this section, the respective State licensing boards having jurisdiction, and the Division of Facility Services, shall communicate the requirements of this section to all licensed practitioners and licensed facilities subject to this section."

SECTION 2. G.S. 90-18(a) reads as rewritten:

"(a) No person shall practice medicine or surgery, or any of the branches thereof, nor in any case prescribe for the cure of diseases unless the person shall have been first licensed and registered so to do in the manner provided in this Article, and if any person shall practice medicine or surgery without being duly licensed and registered, as provided in this Article, the person shall not be allowed to maintain any action to collect any fee for such services. The person so practicing without license shall be guilty of a Class 1 ~~misdemeanor.~~misdemeanor, except that if the person so practicing without a license is an out-of-state practitioner who has not been licensed and registered to practice medicine or surgery in this State, the person shall be guilty of a Class I felony.

SECTION 3. The State licensing boards subject to G.S. 90-681, as enacted by this act, and the Division of Facility Services of the Department of Health and Human Services shall report to the 2006 Regular Session of the 2005 General Assembly upon its convening. The report shall indicate efforts made to apprise licensed practitioners and to evaluate licensed practitioners' and licensed health care facilities' compliance with the requirements of G.S. 90-681, as enacted by this act.

SECTION 4. This act becomes effective December 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 636
Committee Substitute Favorable 5/31/05
Third Edition Engrossed 6/1/05
PROPOSED SENATE COMMITTEE SUBSTITUTE H636-PCS60523-SQ-34

Short Title: Anatomic Pathology Services/Provider Billing. (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE DISCLOSURE OF MARKUPS OF ANATOMIC PATHOLOGY SERVICES BY PHYSICIANS, HOSPITALS, DENTISTS, AND PODIATRISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Pathology Services Billing.

"**§ 90-681. Billing of anatomic pathology services.**

(a) It shall be unlawful for any person licensed to practice medicine, podiatry, or dentistry in this State to bill a patient, entity, or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the licensed practitioner discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement:

(1) The amounts charged by the laboratory for the anatomic pathology service;

(2) Any other charge that has been included in the bill; and

(3) The name of the licensed practitioner performing or supervising the anatomic pathology service.

The disclosure required under this subsection shall be printed in a 10-point or higher font size.

(b) It shall be unlawful for any hospital licensed in this State to bill a patient, entity, or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the hospital

discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement:

(1) The amounts charged by the laboratory for the professional anatomic pathology services;

(2) Any other charge that has been included in the bill; and

(3) The name of the licensed practitioner performing or supervising the anatomic pathology service.

The disclosure required under this subsection shall be printed in a 10-point or higher font size.

(c) A bill for anatomic pathology services submitted to a patient, entity, or person for payment shall disclose the name and address of the laboratory performing the professional component of the service.

(d) The requirements of subsections (a) and (b) of this section shall not apply to:

(1) A licensed practitioner performing or supervising anatomic pathology services, or

(2) A hospital or physician group practice where a physician employee or physician under contract to a hospital or a physician group practice is providing or supervising anatomic pathology services and is compensated by the hospital or physician group practice for the services.

(e) As used in this section, the term "anatomic pathology services" means:

(1) Histopathology or surgical pathology meaning the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician;

(2) Cytopathology meaning the examination of cells from fluids, aspirates, washings, brushings, or smears, including the Pap test examination performed by a physician or under the supervision of a physician;

(3) Hematology meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;

(4) Subcellular pathology and molecular pathology; and

(5) Blood-banking services performed by pathologists.

(f) Nothing in this section shall be construed to require the disclosure of the terms or conditions of a contract for the provision of anatomic pathology services between a managed care organization and a hospital or between a managed care organization and a physician's practice.

(g) The requirements of subsections (a) and (b) of this section shall not apply to a referring laboratory providing anatomic pathology services for services performed by that laboratory in instances where one or more samples must be sent for a second medical opinion on a specimen.

(h) Nothing in this section shall be construed as a prohibition on a physician requesting the anatomic pathology services of more than one clinical laboratory for a second medical opinion on a specimen.

(i) Each intentional failure to disclose in violation of subsections (a), (b), or (c) of this section is a separate Class 3 misdemeanor offense punishable by a fine of two hundred fifty dollars ($250.00).

(j) The respective State licensing boards having jurisdiction over practitioners subject to this section may revoke, suspend, or deny renewal of the license of a practitioner who violates this section. Each State licensing board having jurisdiction may take disciplinary action on a finding by the board of intentional violation or an ongoing pattern of violations in the absence of a misdemeanor conviction.

(k) Not later than six months from the effective date of this section, the respective State licensing boards having jurisdiction, and the Division of Facility Services, shall communicate the requirements of this section to all licensed practitioners and licensed facilities subject to this section."

SECTION 2. G.S. 90-18(a) reads as rewritten:

"(a) No person shall practice medicine or surgery, or any of the branches thereof, nor in any case prescribe for the cure of diseases unless the person shall have been first licensed and registered so to do in the manner provided in this Article, and if any person shall practice medicine or surgery without being duly licensed and registered, as provided in this Article, the person shall not be allowed to maintain any action to collect any fee for such services. The person so practicing without license shall be guilty of a Class 1 ~~misdemeanor.~~misdemeanor, except that if the person so practicing without a license is an out-of-state practitioner who has not been licensed and registered to practice medicine or surgery in this State, the person shall be guilty of a Class I felony."

SECTION 3. The State licensing boards subject to G.S. 90-681, as enacted by this act, and the Division of Facility Services of the Department of Health and Human Services shall report to the 2006 Regular Session of the 2005 General Assembly upon its convening. The report shall indicate efforts made to apprise licensed practitioners and to evaluate licensed practitioners' and licensed health care facilities' compliance with the requirements of G.S. 90-681, as enacted by this act.

SECTION 4. This act becomes effective December 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 636

Committee Substitute Favorable 5/31/05

Third Edition Engrossed 6/1/05

Short Title: Anatomic Pathology Services/Provider Billing. (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE DISCLOSURE OF MARKUPS OF ANATOMIC PATHOLOGY SERVICES BY PHYSICIANS, HOSPITALS, DENTISTS, AND PODIATRISTS.

The General Assembly of North Carolina enacts:

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

"Article 40.

"Pathology Services Billing.

"**§ 90-681. Billing of anatomic pathology services.**

(a) It shall be unlawful for any person licensed to practice medicine, podiatry, or dentistry in this State to bill a patient, entity, or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the licensed practitioner discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement:

(1) The amounts charged by the laboratory for the anatomic pathology service;

(2) Any other charge that has been included in the bill, and

(3) The name of the licensed practitioner performing or supervising the anatomic pathology service.

The disclosure required under this subsection shall be printed in a 10-point or higher font size.

(b) It shall be unlawful for any hospital licensed in this State to bill a patient, entity, or person for anatomic pathology services in an amount in excess of the amount charged by the clinical laboratory for performing the service unless the hospital discloses conspicuously on the itemized bill or statement, or in writing by a separate itemized disclosure statement:

(1) The amounts charged by the laboratory for the professional anatomic pathology services;
(2) Any other charge that has been included in the bill, and
(3) The name of the licensed practitioner performing or supervising the anatomic pathology service.

The disclosure required under this subsection shall be printed in a 10-point or higher font size.

(c) A bill for anatomic pathology services submitted to a patient, entity, or person for payment shall disclose the name and address of the laboratory performing the professional component of the service.

(d) The requirements of subsections (a) and (b) of this section shall not apply to:
(1) A licensed practitioner performing or supervising anatomic pathology services, or
(2) A hospital or physician group practice where a physician employee or physician under contract to a hospital or a physician group practice is providing or supervising anatomic pathology services and is compensated by the hospital or physician group practice for the services.

(e) As used in this section, the term "anatomic pathology services" means:
(1) Histopathology or surgical pathology meaning the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician;
(2) Cytopathology meaning the examination of cells from fluids, aspirates, washings, brushings, or smears, including the Pap test examination performed by a physician or under the supervision of a physician;
(3) Hematology meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;
(4) Subcellular pathology and molecular pathology; and
(5) Blood-banking services performed by pathologists.

(f) Nothing in this section shall be construed to require the disclosure of the terms or conditions of a contract for the provision of anatomic pathology services between a managed care organization and a hospital or between a managed care organization and a physician's practice.

(g) The requirements of subsections (a) and (b) of this section shall not apply to a referring laboratory providing anatomic pathology services for services performed by that laboratory in instances where one or more samples must be sent for a second medical opinion on a specimen.

(h) Nothing in this section shall be construed as a prohibition on a physician requesting the anatomic pathology services of more than one clinical laboratory for a second medical opinion on a specimen.

(i) Each intentional failure to disclose in violation of subsections (a), (b), or (c) of this section is a separate Class 3 misdemeanor offense punishable by a fine of two hundred fifty dollars ($250.00).

(j) The respective State licensing boards having jurisdiction over practitioners subject to this section may revoke, suspend, or deny renewal of the license of a practitioner that violates this section. Each State licensing board having jurisdiction may take disciplinary action on a finding by the board of intentional violation or an ongoing pattern of violations in the absence of a misdemeanor conviction.

(k) Not later than six months from the effective date of this section, the respective State licensing boards having jurisdiction, and the Division of Facility Services, shall communicate the requirements of this section to all licensed practitioners and licensed facilities subject to this section."

SECTION 2. The State licensing boards subject to G.S. 90-681, as enacted by this act, and the Division of Facility Services of the Department of Health and Human Services shall report to the 2006 Regular Session of the 2005 General Assembly upon its convening. The report shall indicate efforts made to apprise licensed practitioners and to evaluate licensed practitioners and licensed health care facilities of the requirements of G.S. 90-681, as enacted by this act.

SECTION 3. This act becomes effective December 1, 2005.

HOUSE BILL 1327:
Crim. Record Checks/Psychology Practice Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	August 9, 2005
Introduced by:	Reps. Harrison, Martin, Wiley	**Summary by:**	Sara Kamprath
Version:	Third Edition		Committee Staff

SUMMARY: House Bill 1327 provides for criminal history background checks of applicants for licensure and certain licensees under the Psychology Practice Act. The act is effective when it becomes law.

BILL ANALYSIS: House Bill 1327 allows the North Carolina Psychology Board (Board) to request that an applicant for licensure or reinstatement of a license or a licensed psychologist or psychological associate currently under investigation by the Board consent to a criminal background check.

The bill authorizes the Board to obtain fingerprints from the applicant or licensee and submit them to the State Bureau of Investigation (SBI) for a state and national criminal history check. The SBI is authorized to charge a fee for the background check.

The Board, when acting reasonably and in compliance with the bill, is granted limited immunity for a denial or revocation of a license based on information provided in the criminal history check.

H1327e3-SMRJ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 1327

Committee Substitute Favorable 5/25/05
Committee Substitute #2 Favorable 7/7/05

Short Title: Crim. Record Checks/Psychology Practice Act. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE DEPARTMENT OF JUSTICE TO CONDUCT CRIMINAL HISTORY RECORD CHECKS FROM STATE AND NATIONAL REPOSITORIES OF CRIMINAL HISTORY OF APPLICANTS FOR LICENSURE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.4(e) reads as rewritten:

"(e) Nothing in this Article shall be construed to prevent qualified members of other professional groups licensed or certified under the laws of this State from rendering services ~~consistent with their professional training and code of ethics,~~within the scope of practice, as defined in the statutes regulating those professional practices, provided they do not hold themselves out to the public by any title or description stating or implying that they are psychologists or are licensed, certified, or registered to practice psychology."

SECTION 2. Article 18A of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-270.22. Criminal history record checks of applicants for licensure and licensees.**

(a) The Board may request that an applicant for licensure or reinstatement of a license or that a licensed psychologist or psychological associate currently under investigation by the Board for allegedly violating this Article consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure or reinstatement of a license to an applicant or take disciplinary action against a licensee, including revocation of a license. The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant or licensee to be checked, a form signed by the applicant or licensee consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and

any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) Limited Immunity. – The Board, its officers and employees, acting reasonably and in compliance with this section, shall be immune from civil liability for denying licensure or reinstatement of a license to an applicant or the revocation of a license or other discipline of a licensee based on information provided in the applicant's or licensee's criminal history record check."

SECTION 3. Article 4 of Chapter 114 of the General Statutes is amended by adding the following new section to read:

"**§ 114-19.16. Criminal record checks of applicants for licensure and licensees.**

The Department of Justice may provide to the North Carolina Psychology Board from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure or reinstatement of a license to practice psychology or a licensed psychologist or psychological associate under Article 18A of Chapter 90 of the General Statutes. Along with the request, the Board shall provide to the Department of Justice the fingerprints of the applicant or licensee, a form signed by the applicant or licensee consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The applicant's or licensee's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

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

HOUSE BILL 855:
Child Nutrition Standards

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	August 9, 2005
Introduced by:	Rep. Insko	**Summary by:**	Sara Kamprath
Version:	Second Edition		Legislative Analyst

SUMMARY: ***House Bill 855 directs the State Board of Education to establish nutrition standards that will gradually increase the amounts of fruits, vegetables, and whole grain products in available items for school meals, a la carte foods and beverages, and the After School Snack Program. At the same time the standards will promote a decrease in items high in total fat, trans fat, saturated fat, and sugar. The nutrition standards shall be implemented first in the elementary schools followed by the middle schools and then high schools.***

BILL ANALYSIS: The State Board of Education shall consult with a cross section of local directors of child nutrition services in the development of the statewide nutrition standards for school meals, a la carte foods and beverages and items served in the After School Snack Program. The bill requires all elementary schools to reach basic level by the end of the 2007-2008 school year with middle schools and high schools to follow. Before statewide implementation, the State Board of Education shall pilot the nutrition standards in the elementary school pilots established under Section 7.17 of S.L. 2004-124, 8 middle schools and 8 high schools. The child nutrition programs of participating schools will be held financially harmless during the pilots. The Child Nutrition Services Section of the Department of Public Instruction will be responsible for collecting and interpreting data from the pilots, for modifying the nutrition standards, and for monitoring the progress of the local school administrative units in meeting the standards. The Child Nutrition Services Section shall make an annual report to the State Board of Education and the Joint Legislative Education Oversight Committee on the progress of each local school administrative unit in implementing the nutrition standards.

H0855e2-SMRJ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 855

Committee Substitute Favorable 5/31/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H855-PCS30363-RJ-29

Short Title: Child Nutrition Standards. (Public)

Sponsors:

Referred to:

March 22, 2005

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO ESTABLISH STATEWIDE NUTRITION STANDARDS FOR SCHOOL MEALS, A LA CARTE FOODS AND BEVERAGES, AND THE AFTER SCHOOL SNACK PROGRAM ADMINISTERED BY THE DEPARTMENT OF PUBLIC INSTRUCTION AND CHILD NUTRITION PROGRAMS OF LOCAL SCHOOL ADMINISTRATIVE UNITS, AS RECOMMENDED BY THE STUDY COMMITTEE FOR CHILDHOOD OVERWEIGHT/OBESITY OF THE HEALTH AND WELLNESS TRUST FUND.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 17 of Chapter 115C of the General Statutes is amended by adding the following new section to read:

"**§ 115C-264.3. Child Nutrition Program standards.**

The State Board of Education, in direct consultation with a cross section of local directors of child nutrition services, shall establish statewide nutrition standards for school meals, a la carte foods and beverages, and items served in the After School Snack Program administered by the Department of Public Instruction and child nutrition programs of local school administrative units. The nutrition standards will promote gradual changes to increase fruits and vegetables, increase whole grain products, and decrease foods high in total fat, trans fat, saturated fat, and sugar. The nutrition standards adopted by the State Board of Education shall be implemented initially in elementary schools. All elementary schools shall achieve a basic level by the end of the 2007-2008 school year, followed by middle schools and then high schools."

SECTION 2. The State Board of Education may use "Eat Smart: North Carolina's Recommended Standards for All Foods Available in School" and the "United States Dietary Guidelines" as references for establishing the nutrition standards under Section 1 of this act. In addition to the elementary school pilots established by Section

7.17 of S.L. 2004-124, the nutrition standards will also be piloted prior to statewide implementation in a minimum of eight middle schools and eight high schools at a time to be determined by the State Board of Education. The pilots shall be conducted in a manner that will hold the child nutrition program of a participating local school administrative unit financially harmless for its participation in the pilot project. It shall be the responsibility of the Child Nutrition Services Section of the Department of Public Instruction to oversee the pilot project, collect data from the pilots, interpret the data, and develop written guidance based on the outcomes of the pilots. The Child Nutrition Services Section of the Department of Public Instruction shall modify the nutrition standards as needed based on several criteria, including, but not limited to, the results of the pilot projects, current science, best practices in the food and beverage industry, and the availability and affordability of new foods and beverages. The Child Nutrition Services Section of the Department of Public Instruction shall monitor the progress of each local school administrative unit toward achieving the nutrition standards and shall provide technical assistance and training as needed to assist local school administrative units in implementing the nutrition standards. The Child Nutrition Services Section of the Department of Public Instruction shall report annually on the progress of each local school administrative unit to the State Board of Education and to the Joint Legislative Education Oversight Committee.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 855

Committee Substitute Favorable 5/31/05

Short Title: Child Nutrition Standards. (Public)

Sponsors:

Referred to:

March 22, 2005

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO ESTABLISH STATEWIDE NUTRITION STANDARDS FOR SCHOOL MEALS, A LA CARTE FOODS AND BEVERAGES, AND THE AFTER SCHOOL SNACK PROGRAM ADMINISTERED BY THE DEPARTMENT OF PUBLIC INSTRUCTION AND CHILD NUTRITION PROGRAMS OF LOCAL SCHOOL ADMINISTRATIVE UNITS, AS RECOMMENDED BY THE STUDY COMMITTEE FOR CHILDHOOD OVERWEIGHT/OBESITY OF THE HEALTH AND WELLNESS TRUST FUND.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 17 of Chapter 115C of the General Statutes is amended by adding the following new section to read:

"**§ 115C-264.2. Child Nutrition Program standards.**

The State Board of Education, in direct consultation with a cross section of local directors of child nutrition services, shall establish statewide nutrition standards for school meals, a la carte foods and beverages, and items served in the After School Snack Program administered by the Department of Public Instruction and child nutrition programs of local school administrative units. The nutrition standards will promote gradual changes to increase fruits and vegetables, increase whole grain products, and decrease foods high in total fat, trans fat, saturated fat, and sugar. The nutrition standards adopted by the State Board of Education shall be implemented initially in elementary schools. All elementary schools shall achieve a basic level by the end of the 2007-2008 school year, followed by middle schools and then high schools."

SECTION 2. The State Board of Education may use "Eat Smart: North Carolina's Recommended Standards for All Foods Available in School" and the "United States Dietary Guidelines" as references for establishing the nutrition standards under Section 1 of this act. In addition to the elementary school pilots established by Section 7.17 of S.L. 2004-124, the nutrition standards will also be piloted prior to statewide implementation in a minimum of eight middle schools and eight high schools at a time

to be determined by the State Board of Education. The pilots shall be conducted in a manner that will hold the child nutrition program of a participating local school administrative unit financially harmless for its participation in the pilot project. It shall be the responsibility of the Child Nutrition Services Section of the Department of Public Instruction to oversee the pilot project, collect data from the pilots, interpret the data, and develop written guidance based on the outcomes of the pilots. The Child Nutrition Services Section of the Department of Public Instruction shall modify the nutrition standards as needed based on several criteria, including, but not limited to, the results of the pilot projects, current science, best practices in the food and beverage industry, and the availability and affordability of new foods and beverages. The Child Nutrition Services Section of the Department of Public Instruction shall monitor the progress of each local school administrative unit toward achieving the nutrition standards and shall provide technical assistance and training as needed to assist local school administrative units in implementing the nutrition standards. The Child Nutrition Services Section of the Department of Public Instruction shall report annually on the progress of each local school administrative unit to the State Board of Education and to the Joint Legislative Education Oversight Committee.

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

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **AUGUST 10, 2005**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Keene	NC Medical Society
Mike Waters	NCRPA
Megan Garrett	Student
Becky Garrett	NC Therapeutic Recreation Cert. Boa
AMW UNK	DUHS
David Barnes	Poyner Spruill LLP
Mike Arnold	Lt. Gov. office
Margaret Westbrook	KCLH
Leanne Winnie	NCSBA
[illegible]	[illegible]
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **AUGUST 10, 2005**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sondra Panico	NC Dept of Justice
David Fox	Alley Associates
Elizabeth Cloud	NCPA

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

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

Thursday, August 11, 2005

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

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

H.B. **1121** Direct Solicitation by Health Care Providers.

Draft Number:	PCS 80452
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE

Wednesday, August 11, 2005
6:00 A.M.
Senate Chamber

MINUTES

The Senate Health Care Committee met at 6:00 A.M. on Wednesday, August 11, 2005, around the desk of Senator William R. Purcell in the Senate Chamber. Nine members were present. Senator Purcell presided.

A proposed Senate committee was presented for HB 1121. *Direct Solicitation by Health Care Providers.* After a brief discussion Senator Bingham moved for an unfavorable report as to the bill, but favorable for the proposed Senate committee substitute, and the motion passed.

The meeting adjourned at 6:10.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Joyce Hodge, Committee Assistant

SENATE
COMMITTE SUBSTITUTE

AUG 11 2005

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

ADOPTED D2

H

HOUSE BILL 1121

~~PROPOSED SENATE COMMITTEE SUBSTITUTE H1121-PCS80452-SQ-45~~
Senate Health Care Committee Substitute Adopted 8/11/05

Short Title: Hospital Authority. (Public)

Sponsors:

Referred to:

April 6, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MERGER OF A HOSPITAL AUTHORITY CREATED BY A CITY AND A CHARITABLE OR RELIGIOUS CORPORATION OR A HOSPITAL AUTHORITY IN THE COUNTY IN WHICH THE CITY IS LOCATED AND RELATING TO PUBLIC HOSPITAL INVESTMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 55A of the General Statutes is amended by adding the following new section to read:

"**§ 55A-11-10. Merger with certain charitable or religious corporation or hospital authority.**

(a) A hospital authority created by a city may merge into a charitable or religious corporation having its principal office in the county in which the city is located, under a plan of merger approved by the city and the county and by a majority of the members of the board of commissioners of such authority and by or for the corporation as provided in G.S. 55A-11-03.

(b) A hospital authority created by a city may merge into a hospital authority created by the county in which the city is located, pursuant to a plan of merger approved by the city and the county and by a majority of the members of the board of commissioners of each authority.

(c) The plan of merger shall include all of the following:

(1) The name of the city hospital authority and the charitable or religious corporation or the county hospital authority planning to merge and the name of the surviving charitable or religious corporation or county hospital authority into which such city hospital authority plans to merge.

(2) The terms and conditions of the merger.

(3) Any amendments to the articles or certificate of incorporation or bylaws of the surviving charitable or religious corporation or the surviving county hospital authority to be effected by the merger.

(4) Other provisions relating to the merger.

(d) After the plan of merger is approved, the surviving charitable or religious corporation or the surviving county hospital authority shall deliver to the Secretary of State for filing articles of merger that include all of the following:

(1) The plan of merger.

(2) In the case of a merger of a city hospital authority into a charitable or religious corporation, a statement that the plan of merger was approved by the city and by a majority of the members of the board of commissioners of the city hospital authority and the statements required under G.S. 55A-11-04(a)(2), (3), or (4); or

(3) In the case of a merger of a city hospital authority into a county hospital authority, a statement that the plan of merger was approved by the city and the county and a majority of each of the boards of commissioners of the authorities.

(e) A merger takes effect upon the effective date of the articles of merger.

(f) Certificates of merger shall also be registered as provided in G.S. 47-18.1.

(g) All of the following shall occur upon an effective merger under this section:

(1) The separate existence of the city hospital authority that merges into the charitable or religious corporation or into the county hospital authority ceases.

(2) The title to all real estate and other property owned by the hospital authority is vested in the surviving charitable or religious corporation or in the surviving county hospital authority without reversion or impairment subject to any and all conditions to which the property was subject prior to the merger.

(3) The surviving charitable or religious corporation or the surviving county hospital authority has all liabilities and obligations of the city hospital authority and the charitable or religious corporation or the county hospital authority party to the merger.

(4) A proceeding pending by or against the city hospital authority and the charitable or religious corporation or the county hospital authority party to the merger may be continued as if the merger did not occur or the surviving charitable or religious corporation or the surviving county hospital authority may be substituted in the proceeding for the city hospital authority whose existence ceased.

(5) The articles or certificate of incorporation and bylaws of the surviving charitable or religious corporation or the surviving county hospital authority are amended to the extent provided in the plan of merger.

(6) Any bequest, devise, gift, grant, or promise contained in a will or other instrument of donation, subscription, or conveyance that is made to a city hospital authority that has merged into a charitable or religious

corporation or into a county hospital authority and that takes effect or remains payable after the merger, inures to the surviving charitable or religious corporation or the surviving county hospital authority unless the will or other instrument otherwise specifically provides.

(h) A merger pursuant to the provisions of this section will not be deemed to be a sale or conveyance of a hospital facility under or pursuant to G.S. 131E-8, 131E-13, or 131E-14 of the Municipal Hospital Act (Part 1, Article 2, Chapter 131E of the General Statutes) and G.S. 131E-13(d) will not be applicable to such merger."

SECTION 2. This act applies only to the merger of a hospital authority formed by a city in a county with a population of less than 150,000 as of the most recent U.S. Census and either (i) a charitable or religious corporation formed on or before the effective date of this act having its principal office located in such county as of the effective date of this act, or (ii) a hospital authority formed after the effective date of this act by the county in which the city is located.

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

HOUSE BILL 1121
Senate Health Care Committee Substitute Adopted 8/11/05

Short Title: Hospital Authority. (Public)

Sponsors:

Referred to:

April 6, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MERGER OF A HOSPITAL AUTHORITY CREATED BY A CITY AND A CHARITABLE OR RELIGIOUS CORPORATION OR A HOSPITAL AUTHORITY IN THE COUNTY IN WHICH THE CITY IS LOCATED AND RELATING TO PUBLIC HOSPITAL INVESTMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 55A of the General Statutes is amended by adding the following new section to read:

"**§ 55A-11-10. Merger with certain charitable or religious corporation or hospital authority.**

(a) A hospital authority created by a city may merge into a charitable or religious corporation having its principal office in the county in which the city is located, under a plan of merger approved by the city and the county and by a majority of the members of the board of commissioners of such authority and by or for the corporation as provided in G.S. 55A-11-03.

(b) A hospital authority created by a city may merge into a hospital authority created by the county in which the city is located, pursuant to a plan of merger approved by the city and the county and by a majority of the members of the board of commissioners of each authority.

(c) The plan of merger shall include all of the following:

(1) The name of the city hospital authority and the charitable or religious corporation or the county hospital authority planning to merge and the name of the surviving charitable or religious corporation or county hospital authority into which such city hospital authority plans to merge.

(2) The terms and conditions of the merger.

(3) Any amendments to the articles or certificate of incorporation or bylaws of the surviving charitable or religious corporation or the surviving county hospital authority to be effected by the merger.

(4) Other provisions relating to the merger.

(d) After the plan of merger is approved, the surviving charitable or religious corporation or the surviving county hospital authority shall deliver to the Secretary of State for filing articles of merger that include all of the following:

(1) The plan of merger.

(2) In the case of a merger of a city hospital authority into a charitable or religious corporation, a statement that the plan of merger was approved by the city and by a majority of the members of the board of commissioners of the city hospital authority and the statements required under G.S. 55A-11-04(a)(2), (3), or (4); or

(3) In the case of a merger of a city hospital authority into a county hospital authority, a statement that the plan of merger was approved by the city and the county and a majority of each of the boards of commissioners of the authorities.

(e) A merger takes effect upon the effective date of the articles of merger.

(f) Certificates of merger shall also be registered as provided in G.S. 47-18.1.

(g) All of the following shall occur upon an effective merger under this section:

(1) The separate existence of the city hospital authority that merges into the charitable or religious corporation or into the county hospital authority ceases.

(2) The title to all real estate and other property owned by the hospital authority is vested in the surviving charitable or religious corporation or in the surviving county hospital authority without reversion or impairment subject to any and all conditions to which the property was subject prior to the merger.

(3) The surviving charitable or religious corporation or the surviving county hospital authority has all liabilities and obligations of the city hospital authority and the charitable or religious corporation or the county hospital authority party to the merger.

(4) A proceeding pending by or against the city hospital authority and the charitable or religious corporation or the county hospital authority party to the merger may be continued as if the merger did not occur or the surviving charitable or religious corporation or the surviving county hospital authority may be substituted in the proceeding for the city hospital authority whose existence ceased.

(5) The articles or certificate of incorporation and bylaws of the surviving charitable or religious corporation or the surviving county hospital authority are amended to the extent provided in the plan of merger.

(6) Any bequest, devise, gift, grant, or promise contained in a will or other instrument of donation, subscription, or conveyance that is made to a city hospital authority that has merged into a charitable or religious

corporation or into a county hospital authority and that takes effect or remains payable after the merger, inures to the surviving charitable or religious corporation or the surviving county hospital authority unless the will or other instrument otherwise specifically provides.

(h) A merger pursuant to the provisions of this section will not be deemed to be a sale or conveyance of a hospital facility under or pursuant to G.S. 131E-8, 131E-13, or 131E-14 of the Municipal Hospital Act (Part 1, Article 2, Chapter 131E of the General Statutes) and G.S. 131E-13(d) will not be applicable to such merger."

SECTION 2. This act applies only to the merger of a hospital authority formed by a city in a county with a population of less than 150,000 as of the most recent U.S. Census and either (i) a charitable or religious corporation formed on or before the effective date of this act having its principal office located in such county as of the effective date of this act, or (ii) a hospital authority formed after the effective date of this act by the county in which the city is located.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1121
PROPOSED SENATE COMMITTEE SUBSTITUTE H1121-PCS80452-SQ-45

Short Title: Hospital Authority. (Public)

Sponsors:

Referred to:

April 6, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MERGER OF A HOSPITAL AUTHORITY CREATED BY A CITY AND A CHARITABLE OR RELIGIOUS CORPORATION OR A HOSPITAL AUTHORITY IN THE COUNTY IN WHICH THE CITY IS LOCATED AND RELATING TO PUBLIC HOSPITAL INVESTMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 55A of the General Statutes is amended by adding the following new section to read:

"**§ 55A-11-10. Merger with certain charitable or religious corporation or hospital authority.**

(a) A hospital authority created by a city may merge into a charitable or religious corporation having its principal office in the county in which the city is located, under a plan of merger approved by the city and the county and by a majority of the members of the board of commissioners of such authority and by or for the corporation as provided in G.S. 55A-11-03.

(b) A hospital authority created by a city may merge into a hospital authority created by the county in which the city is located, pursuant to a plan of merger approved by the city and the county and by a majority of the members of the board of commissioners of each authority.

(c) The plan of merger shall include all of the following:

(1) The name of the city hospital authority and the charitable or religious corporation or the county hospital authority planning to merge and the name of the surviving charitable or religious corporation or county hospital authority into which such city hospital authority plans to merge.

(2) The terms and conditions of the merger.

(3) Any amendments to the articles or certificate of incorporation or bylaws of the surviving charitable or religious corporation or the surviving county hospital authority to be effected by the merger.

(4) Other provisions relating to the merger.

(d) After the plan of merger is approved, the surviving charitable or religious corporation or the surviving county hospital authority shall deliver to the Secretary of State for filing articles of merger that include all of the following:

(1) The plan of merger.

(2) In the case of a merger of a city hospital authority into a charitable or religious corporation, a statement that the plan of merger was approved by the city and by a majority of the members of the board of commissioners of the city hospital authority and the statements required under G.S. 55A-11-04(a)(2), (3), or (4); or

(3) In the case of a merger of a city hospital authority into a county hospital authority, a statement that the plan of merger was approved by the city and the county and a majority of each of the boards of commissioners of the authorities.

(e) A merger takes effect upon the effective date of the articles of merger.

(f) Certificates of merger shall also be registered as provided in G.S. 47-18.1.

(g) All of the following shall occur upon an effective merger under this section:

(1) The separate existence of the city hospital authority that merges into the charitable or religious corporation or into the county hospital authority ceases.

(2) The title to all real estate and other property owned by the hospital authority is vested in the surviving charitable or religious corporation or in the surviving county hospital authority without reversion or impairment subject to any and all conditions to which the property was subject prior to the merger.

(3) The surviving charitable or religious corporation or the surviving county hospital authority has all liabilities and obligations of the city hospital authority and the charitable or religious corporation or the county hospital authority party to the merger.

(4) A proceeding pending by or against the city hospital authority and the charitable or religious corporation or the county hospital authority party to the merger may be continued as if the merger did not occur or the surviving charitable or religious corporation or the surviving county hospital authority may be substituted in the proceeding for the city hospital authority whose existence ceased.

(5) The articles or certificate of incorporation and bylaws of the surviving charitable or religious corporation or the surviving county hospital authority are amended to the extent provided in the plan of merger.

(6) Any bequest, devise, gift, grant, or promise contained in a will or other instrument of donation, subscription, or conveyance that is made to a city hospital authority that has merged into a charitable or religious

corporation or into a county hospital authority and that takes effect or remains payable after the merger, inures to the surviving charitable or religious corporation or the surviving county hospital authority unless the will or other instrument otherwise specifically provides.

(h) A merger pursuant to the provisions of this section will not be deemed to be a sale or conveyance of a hospital facility under or pursuant to G.S. 131E-8, 131E-13, or 131E-14 of the Municipal Hospital Act (Part 1, Article 2, Chapter 131E of the General Statutes) and G.S. 131E-13(d) will not be applicable to such merger."

SECTION 2. This act applies only to the merger of a hospital authority formed by a city in a county with a population of less than 150,000 as of the most recent U.S. Census and either (i) a charitable or religious corporation formed on or before the effective date of this act having its principal office located in such county as of the effective date of this act, or (ii) a hospital authority formed after the effective date of this act by the county in which the city is located.

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

SENATE HEALTH CARE COMMITTEE
Thursday, August 25, 2005
2:00 A.M.
Senate Chamber

MINUTES

The Senate Health Care Committee met at 2:00 A.M. on Thursday, August 25, 2005, around the desk of Senator William R. Purcell in the Senate Chamber. Fifteen members were present. Senator Purcell presided.

A proposed Senate committee was presented for HB 1060. *Hospital License/Conforming Change.* After a brief discussion Senator Dannelly moved for an unfavorable report as to the bill, but favorable for the proposed Senate committee substitute, and the motion passed.

The meeting adjourned at 2:07.

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

Stan Bingham
Senator Stan Bingham, Co-Chair

Bonnie McNeil
Bonnie McNeil, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 1060

Committee Substitute Favorable 4/6/05

Senate Health Care Committee Substitute Adopted 8/23/05

Short Title: Hospital License/Conforming Change. (Public)

Sponsors:

Referred to:

March 31, 2005

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE DEFINITION OF "CRITICAL ACCESS HOSPITAL" TO CONFORM TO FEDERAL LAW; AND RELATING TO REGULATION OF GASTROINTESTINAL ENDOSCOPY ROOMS IN LICENSED HEALTH SERVICE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-76(1a) reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

...

(1a) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development. To be designated as a critical access hospital under this subdivision, the hospital must ~~meet the requirements of federal law for certification as a critical access hospital.~~be certified as a critical access hospital pursuant to 42 CFR Part 485 Subpart F. The North Carolina Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development may designate a hospital located in a Metropolitan Statistical Area as a rural hospital for the purposes of the critical access hospital program if the hospital is located in a county with twenty-five percent (25%) or more rural residents as defined by the most recent United States decennial census."

SECTION 2. G.S. 131E-76 is amended by inserting the following new subdivisions, in alphabetical order, to read:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

...

(8) 'Gastrointestinal endoscopy room' means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(9) 'Operating room' means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room."

SECTION 3. G.S. 131E-77(e) reads as rewritten:

"(e) The Department shall issue the license to the operator of the hospital who shall not transfer or assign it except with the written approval of the Department. The license shall designate the number and types of inpatient beds, the number of operating rooms, and the number of gastrointestinal endoscopy rooms."

SECTION 4. G.S. 131E-146 reads as rewritten:

"**§ 131E-146. Definitions.**

As used in this Part, unless otherwise specified:

(1) "Ambulatory surgical facility" means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room as defined in subdivision (1c) of this section or at least one gastrointestinal endoscopy room as defined in subdivision (1b) of this section and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under G.S. Chapter 131E, Article 6, Part 4, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision (1a) and which are performed in a physician or dentist's office does not make that office an ambulatory surgical facility.

(1a) "Ambulatory surgical program" means a formal program for providing on a same-day basis those surgical procedures which require local, regional or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to ~~surgery,~~surgery or gastrointestinal endoscopy, to be medically unnecessary.

(1b) "Gastrointestinal endoscopy room" means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(1c) "Operating room" means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.

(2) "Commission" means the North Carolina Medical Care Commission."

SECTION 5. G.S. 131E-175 is amended by adding the following new subdivisions to read:

"**§ 131E-175. Findings of fact.**

The General Assembly of North Carolina makes the following findings:

...

(11) That physicians providing gastrointestinal endoscopy services in unlicensed settings should be given an opportunity to obtain a license to provide those services to ensure the safety of patients and the provision of quality care.

(12) That demand for gastrointestinal endoscopy services is increasing at a substantially faster rate than the general population given the procedure is recognized as a highly effective means to diagnose and prevent cancer."

SECTION 6.(a) G.S. 131E-176(1b) and 131E-176(1c) read as rewritten:

"**§ 131E-176. Definitions.**

...

(1b) "Ambulatory surgical facility" means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room or gastrointestinal endoscopy room, as defined in Article 5 Part 1 and Article 6, Part 4 of this Chapter, and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under G.S. Chapter 131E, Article 6, Part D, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision ~~(1b)~~ (1c) of this section and which are

performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.

(1c) "Ambulatory surgical program" means a formal program for providing on a same-day basis those surgical procedures which require local, regional or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to ~~surgery,~~surgery or gastrointestinal endoscopy, to be medically unnecessary."

SECTION 6.(b) G.S. 131E-176(16)u. reads as rewritten:

"(16) "New institutional health services" means any of the following:

...

u. The construction, development, establishment, increase in the number, or relocation of an operating room or ~~operating rooms,~~gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or ~~operating rooms~~ gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room ~~is or operating rooms are~~ or gastrointestinal endoscopy room is currently located."

SECTION 6.(c) G.S. 131E-176(16) is amended by adding the following new sub-subdivision to read:

"v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005."

SECTION 6.(d) G.S. 131E-176 is amended by adding the following new subdivisions to read:

"(7d) 'Gastrointestinal endoscopy room' means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(18c) 'Operating room' means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room."

SECTION 7. G.S. 131E-178(a) reads as rewritten:

"(a) No person shall offer or develop a new institutional health service without first obtaining a certificate of need from the Department; provided, however, ~~no hospital licensed pursuant to Article 5 of this Chapter that was established to serve a minority population that would not otherwise have been served and that continues to serve a~~

~~minority population may be required to obtain a certificate of need for transferring up to 65 beds to nursing care facility beds.~~no person who provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:

(1) The license application is postmarked for delivery to the Division of Facility Services by December 31, 2006;

(2) The applicant verifies, by affidavit submitted to the Division of Facility Services within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Facility Services of the Department; and

(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.

All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved."

SECTION 8. G.S. 131E-182(a), as amended by Senate Bill 740, 2005 General Assembly, reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that applications for similar proposals in the same service area will be reviewed together. However, there shall not be a review scheduled prior to February 1, 2006, for submission and review of certificate of need applications that propose an increase in the number of licensed gastrointestinal endoscopy rooms. An applicant for a certificate of need to establish a licensed gastrointestinal endoscopy room shall show that it is performing or reasonably projects to perform at least 1,500 gastrointestinal endoscopy procedures per gastrointestinal endoscopy room per year."

SECTION 9. Nothing in Sections 2 through 10 of this act shall be construed to represent legislative intent as to the circumstances under which Medicare or Medicaid certification may be obtained for a provider of ambulatory surgery services.

SECTION 10. This act is effective when it becomes law. Section 8 of this act expires on the effective date of administrative rules adopted consistent with the provisions of this act regarding the number of gastrointestinal endoscopy procedures performed or projected to be performed.

HOUSE BILL 1060

Short Title:	Hospital License/Conforming Change.	(Public)
Sponsors:	Representatives Wright; and Faison.	
Referred to:	Health.	

March 31, 2005

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE DEFINITION OF "CRITICAL ACCESS HOSPITAL" TO CONFORM TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-76(1a) reads as rewritten:

"**§ 131E-76. Definitions.**

As used in this article, unless otherwise specified:

...

(1a) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development. To be designated as a critical access hospital under this subdivision, the hospital must ~~meet the requirements of federal law for certification as a critical access hospital.~~be certified as a critical access hospital pursuant to 42 CFR Part 485 Subpart F."

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

SENATE COMMITTEE ON HEALTH AND HUMAN RESOURCES

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Lorraine Blake 3-5953

Stan Bingham, CoChair
Judy Chriscoe 3-5665

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

Katie Dorsett, Vice Chair
5-3042

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Vernon Malone
Claudette Howell 3-5880

Martin L. Nesbitt, Jr.
Janette Lee 5-3001

Tony Rand

Evelyn Costello 3-9892

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

Shawn Parker, Research
Ben Popkin, Research
Sara Kamprath, Research
Morgan Jones, Research

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0035	Alexander	ADET SCHOOL/FEE/ QUALIS. INCREASE.	*SR	Ch. SL 2005-312	05-09-05	05-18-05
[redacted]045=	Nye	ADULT PROTECTIVE SERVICES TF/ COLLABORATE.	SR	Ch. SL 2005-23	03-16-05	04-13-05
H0239	Wainwright	SMOKING IN PUBLIC PLACES/LOCAL HEALTH DEPT.	*SR	Ch. SL 2005-19	03-23-05	04-13-05
H0277	Glazier	ESTABLISH CHILD ASSESSMENT RESPONSES.	*SR	Ch. SL 2005-55	04-07-05	05-04-05
H0448	Glazier	COMMUNITY COLLEGES EXEMPT FROM SMOKING LAWS.	*SR	Ch. SL 2006-133	06-30-06	07-07-06
H0496	Harrison	STUDENT ASTHMA MEDICATIONS.	*SR	Ch. SL 2005-22	04-05-05	04-20-05
H0613	Harrell	UPDATE CERTIFICATION/ LICENSURE/REC. THERAPY.	*SR	Ch. SL 2005-378	05-24-05	08-10-05
H0636	Nye	ANATOMIC PATHOLOGY SERVICES/PROVIDER BILLING.	*SR	Ch. SL 2005-415	06-02-05	08-10-05
H0686	Gibson	UPDATE DISABILITY STATUTES/SERVICE ANIMALS.	*SR	Ch. SL 2005-450	04-07-05	05-16-05
H0707	Alexander	AMEND STAR-RATED LICENSURE/CHILD CARE FAC.-AB	*SR	Ch. SL 2005-36	04-14-05	04-27-05
H0780	Yongue	NEED-BASED NURSING SCHOLARSHIPS.-AB	*SR	Ch. SL 2005-40	04-18-05	05-04-05
H0855	Insko	CHILD NUTRITION STANDARDS.	*SR	Ch. SL 2005-457	06-02-05	08-10-05
[redacted]869	Wright	PUBLIC HOSPITAL AMENDMENTS/DOWNTOWN FACILITY	*SR	Ch. SL 2005-70	04-13-05	05-25-05
H0874	Goodwin	TITLE CHANGE/SAFETY AND HEALTH REVIEW BOARD.	*SR	Ch. SL 2005-133	05-25-05	06-15-05
H0916	Gillespie	HEMOPHILIA DRUGS/ EXTEND SUNSET ON PRIOR AUTH.	*SR	Ch. SL 2005-83	05-11-05	06-02-05
H1059	Wright	STATE HEALTH PLAN CHANGES.	*SR	Ch. SL 2006-249	06-06-05	07-06-05
H1060	Wright	HOSPITAL LICENSE/ CONFORMING CHANGE.	*SR	Ch. SL 2005-346	04-14-05	08-23-05
H1077	Sherrill	BIRTH CERTIFICATE/ STILLBORN INFANTS.	*S	Ref To Com On Health Care	04-20-05	
H1121	Rayfield	HOSPITAL AUTHORITY.	*SR	Ch. SL 2005-449	05-23-05	08-11-05
H1133	Dickson	DESIGNATE GENERAL ASSEMBLY BUILDINGS NONSMOKING.	*SR	Ch. SL 2006-76	06-05-06	06-14-06
H1194	Weiss	PHYSICAL THERAPISTS/ PROFESSIONAL CORPORATIONS.	*S	Re-ref Com On Health Care	05-30-06	
H1301	L. Allen	PT BD. LIC/STRNGTH BD. MED/PATIENT SAFE ORG.	*SR	Ch. SL 2006-144	05-23-05	06-29-06

'$' 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.

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H1327	Harrison	CRIM. RECORD CHECKS/ PSYCHOLOGY PRACTICE ACT.	*SR	Ch. SL 2006-175	07-14-05	08-10-05
H1330	Jeffus	AUTHORIZE LICENSURE/ ANESTHESIOLOGIST ASST'S.	*S	Ref To Com On Rules, Calendar, and Operations of the House	08-24-05	05-18-06
H1343	Nye	DENTAL INTERN PERMITS.	*SR	Ch. SL 2006-41	06-07-06	06-14-06
H1357	Fisher	AMEND ACUPUNCTURE LAWS/FEES.	*SR	Ch. SL 2005-379	05-18-05	06-15-05
H1482	Pierce	SMOKING IN PUBLIC PLACES/LOCAL HEALTH/ DSS.	*SR	Ch. SL 2005-168	06-06-05	06-22-05
H1493	Cole	PHARMACY QUALITY ASSURANCE PROTECTION ACT.	*SR	Ch. SL 2005-427	08-09-05	08-10-05
H1493	Cole	PHARMACY QUALITY ASSURANCE PROTECTION ACT.	*SR	Ch. SL 2005-427	08-10-05	08-10-05
H1502	Martin	SCHOOLCHILDREN'S HEALTH ACT.	*SR	Ch. SL 2006-143	06-06-06	06-28-06
H1507	Alexander	AMEND INTERPRETER/ TRANSLITERATOR LICENSE ACT.	SR	Ch. SL 2005-299	05-25-05	06-22-05
H1860	Faison	STROKE ADVISORY COUNCIL.	*SR	Ch. SL 2006-197	07-18-06	07-19-06
$ H1895=	**Insko**	**ESTABLISH HIGH-RISK POOL.**	***S**	**Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget**	**07-19-06**	
H1987	Holliman	HEALTH PLANS/CHANGES TO BASIC AND STD.	*SR	Ch. SL 2006-154	06-28-06	07-06-06
H2037	Stiller	MEDICAID REIMBURSE. FOR OCULAR PROSTHETISTS.	*SR	Ch. SL 2006-198	07-12-06	07-18-06
H2052=	Earle	REVIEW OF NC INSTITUTIONAL BIAS REPORT.	S	Ref To Com On Health Care	07-05-06	
H2054=	Earle	ADULT DAY AWARENESS/ STATUS OF STUDY RECOM.	S	Ref To Com On Health Care	07-05-06	
H2059	Earle	LTC FINES POSTED ON INTERNET.	*S	Ref To Com On Health Care	06-20-06	
H2077	Insko	MENTAL HEALTH REFORM CHANGES.	*SR	Ch. SL 2006-142	06-08-06	06-28-06
H2120	Insko	STRENGTHEN LOC OVERSIGHT ROLE.	*SR	Ch. SL 2006-32	06-01-06	06-14-06
H2200=	Cunningham	ENHANCE EMBARGO AUTH/ PROTECT FOOD SUPPLY.	*SR	Ch. SL 2006-80	06-22-06	06-28-06
H2576	Clary	SPECIAL ASSISTANCE IN-HOME ASSIGN.	SR	Ch. SL 2006-156	07-05-06	07-12-06
$ H2699	**Coleman**	**VISION CARE PROGRAM CHANGES.**	***SR**	**Ch. SL 2006-240**	**07-07-06**	**07-18-06**
S0003	Tony Rand	AUTHORIZE COMPETENCY REQ./NC BD. OF NURSING.	*SR	Ch. SL 2005-186	01-27-05	02-23-05

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
S0036=	A. B Swindell	ADULT PROTECTIVE SERVICES TF/ COLLABORATE.	S	Ref To Com On Health Care	02-03-05	
S0040=	A. B Swindell	FALSIFY INFO/ADULT CARE HOME LICENSE/ PENALTY.	S	Ref To Com On Health Care	02-03-05	
$ S0042=	**A. B Swindell**	**HOME CARE CHANGES.**	***S**	**Ref To Com On Aging**	**02-03-05**	**06-01-05**
$ S0045	**Katie G. Dorsett**	**ACCESSIBLE ELECTRONIC INFO ACT/BLIND/ DISABL'D.**	***S**	**Re-ref Com On Appropriations/ Base Budget**	**02-03-05**	**03-10-05**
S0072	Kay R. Hagan	EXPAND COUNTY BOARD OF HEALTH MEMBERSHIP.	*S	Ref To Com On Health	02-08-05	02-23-05
S0083=	Charlie S. Danne	ADET SCHOOL/FEE/ QUALIFICATIONS INCREASE.	*S	Re-ref Com On Finance	02-09-05	02-23-05
S0118=	William R. Purce	MEDICAID CASE MANAGEMENT/ PRESCRIPTION DRUGS.	S	Re-ref Com On Health Care	02-14-05	03-30-05
S0118=	William R. Purce	MEDICAID CASE MANAGEMENT/ PRESCRIPTION DRUGS.	S	Re-ref Com On Health Care	03-31-05	
$ S0119=	**William R. Purce**	**TICKET TO WORK/ MEDICAID ELIGIBILITY.**	***S**	**Re-ref Com On Appropriations/ Base Budget**	**02-14-05**	**04-13-05**
S0120=	William R. Purce	EXPAND MEDICAID ELIGIBILITY TO CHILDREN/200%.	*S	Re-ref Com On Appropriations/ Base Budget	02-14-05	03-16-05
S0124=	William R. Purce	REINVESTMENT OF SAVINGS REALIZED/ COMM. CARE.	S	Re-ref Com On Appropriations/ Base Budget	02-14-05	03-16-05
S0208=	Jeanne H. Lucas	AMEND OCCUPATIONAL THERAPY LAWS/FEE.	*SR	Ch. SL 2005-432	02-24-05	05-03-05
S0216=	Martin L. Nesbit	COORDINATION OF CHILDREN'S SERVICES/ STUDY.	S	Re-ref Com On Appropriations/ Base Budget	02-24-05	04-13-05
S0268	William R. Purce	ANIMAL EXHIBITION SANITATION/"AEDIN'S LAW".	*SR	Ch. SL 2005-191	05-25-05	06-01-05
S0326	Stan Bingham	RETIRED NURSES RETURN TO WORK.	*S	Re-ref Com On Pensions & Retirement and Aging	03-03-05	04-21-05
S0391	Jeanne H. Lucas	HOSPITAL-ACQUIRED INFECTION RATES.	S	Ref To Com On Health Care	03-07-05	
S0394=	David W. Hoyle	AUTHORIZE LICENSURE/ ANESTHESIOLOGIST ASST'S.	S	Ref To Com On Health Care	03-07-05	
S0482=	Katie G. Dorsett	INDOOR ARENA SMOKING REGULATIONS.	SR	Ch. SL 2005-239	03-10-05	03-30-05
S0489	Janet Cowell	COSMETIC ART DEFINITIONS/EXAM FACILITIES.	*SR	Ch. SL 2006-212	03-15-05	06-01-05
S0502	William R. Purce	AMEND STAR-RATED LICENSE FOR CHILD CARE FAC.	S	Ref To Com On Health Care	03-15-05	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
S0506	William R. Purce	CANCER REGISTRY.	SR	Ch. SL 2005-373	03-15-05	03-23-05
S0549=	Austin M. Allran	ABORTION-WOMAN'S RIGHT TO KNOW.	S	Ref To Com On Health Care	03-15-05	
S0572	A. B Swindell	LICENSE ASSISTED LIVING FACIL./ELDERLY.	SR	Ch. SL 2005-66	03-16-05	03-23-05
S0581	James Forrester	PRESCRIPTION MANAGEMENT PROGRAM.	S	Ref To Com On Health Care	03-16-05	
S0650	Jeanne H. Lucas	CLINICAL TRIAL RESULTS PUBLISHED.	S	Ref To Com On Health Care	03-17-05	
S0662=	William R. Purce	MED ADMINISTRATION/ UNLICENSED PERSONNEL.	S	Ref To Com On Health Care	03-17-05	
S0663	William R. Purce	ASTHMA MEDS/STUDENT SELF-ADMINISTRATION.	S	Ref To Com On Health Care	03-17-05	
S0665=	Fletcher L. Hart	PUBLIC HLTH AUTHORITIES/CO. MEDICAID BILLING.	*SR	Ch. SL 2005-459	03-17-05	05-05-05
$ S0673=	**Martin L. Nesbit**	**JOBS FOR ALL ACT.**	**S**	**Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget**	**03-17-05**	
S0680	Stan Bingham	DISAPPROVAL OF CERTAIN RULES.	S	Ref To Com On Health Care	03-17-05	
S0703=	Martin L. Nesbit	RATE AND INFLATIONARY INCREASES/MH PROVIDERS.	S	Re-ref Com On Appropriations/ Base Budget	03-21-05	05-25-05
$ S0705	**Martin L. Nesbit**	**AMEND SUBSTANCE ABUSE LAWS.**	***SR**	**Ch. SL 2005-431**	**04-27-05**	**05-16-05**
S0711=	A. B Swindell	NC DENTAL BOARD/EXAMS & REAL PROPERTY.	*SR	Ch. SL 2005-366	03-21-05	04-07-05
S0740	Tony Rand	CERTIFICATE OF NEED AMENDMENTS.	*SR	Ch. SL 2005-325	03-22-05	05-31-05
S0765	William R. Purce	INCREASE AREA MH/DD/ SAS BD MEMBERSHIP.	S	Ref To Com On Health	03-22-05	03-30-05
S0768	William R. Purce	NC HEALTH CHOICE/ CONTROL UTILIZATION & COST.	*S	Ref To Com On Health Care	03-22-05	
$ S0804	**Fletcher L. Hart**	**PUBLIC HEALTH TASK FORCE/ACCRED. RECOMMEND.**	***SR**	**Ch. SL 2005-369**	**04-27-05**	**05-04-05**
S0830=	Keith Presnell	HEMOPHILIA DRUGS/ REMOVE SUNSET ON PRIOR AUTH.	S	Ref To Com On Health Care	03-23-05	
S0877	William R. Purce	AMEND LAWS/PRAC. OF MED./INC. CERTAIN FEES.	S	Ref to Health Care. If fav, re-ref to Finance	03-23-05	
S0942=	Scott Thomas	ESTABLISH CHILD ASSESSMENT RESPONSES.	S	Ref To Com On Health Care	03-24-05	
S0960	William R. Purce	STUDY CHILD NUTRITION SERVICES INDIR. COSTS.	*S	Ref To Com On Children, Youth and Families	03-24-05	05-12-05
S1009	Kay R. Hagan	AMEND ELECTROLYSIS PRACTICE ACT/FEES.	S	Ref to Health Care. If fav, re-ref to Finance	03-24-05	
S1020=	Malcolm Graham	RESTAURANTS/PROVIDE INFO ON USE OF	S	Ref To Com On Health Care	03-24-05	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		PEANUTS.				
1025=	Eleanor Kinnaird	NATUROPATHIC PHYSICIANS REGISTRATION ACT.	S	Ref To Com On Health Care	03-24-05	
S1028	Janet Cowell	STRENGTHEN LAWS/ COMPOUND'G/ ADMINISTER'G DRUG.	S	Ref To Com On Health Care	03-24-05	
S1040	Philip E. Berger	PROHIBIT HUMAN CLONING.	S	Ref To Com On Health Care	03-24-05	
S1059=	William R. Purce	PERFUSIONISTS LICENSURE.	*SR	Ch. SL 2005-267	03-24-05	05-05-05
S1072	Tony Rand	HOSPITAL LICENSE CHANGES.-AB	*S	Ref To Com On Health	03-24-05	04-13-05
$ S1074	**Tony Rand**	**FACILITY QUALITY AND SAFETY IMPROVEMENTS.**	***S**	**Ref To Com On Health**	**03-24-05**	**05-18-05**
S1092	Robert Lee Hollo	NC MEDICAL BOARD MEMBERSHIP REFORMS/ REPORTS.	S	Ref To Com On Health Care	03-24-05	
S1128	Walter H. Dalton	MEDICAID: NO PREAUTH. FOR CERTAIN DRUGS.	S	Ref To Com On Health Care	03-24-05	
S1153	Bob Atwater	STATE OF THE CHILD ANNUAL REPORT.	S	Ref To Com On Health Care	03-24-05	
S1161=	Tom Apodaca	HOSPICE BRANCH OFFICE NOT NEW INSTL. HLTH. SERV.	*SF	Failed 2nd Reading	03-24-05	05-26-05
S1210	Julia Boseman	REPEAL EYE EXAM REQUIREMENT FOR KINDERGARTEN.	*S	Ref To Com On Health	05-10-06	05-18-06
S1274	Charlie S. Danne	LTC FINES POSTED ON INTERNET.	S	Ref To Com On Health Care	05-11-06	
1275=	**Charlie S. Danne**	**HEALTH CARE PERSONNEL REGISTRY EXPANSION.**	***S**	**Re-ref Com On Appropriations/ Base Budget**	**05-11-06**	**06-22-06**
S1276=	Charlie S. Danne	CAP/DA REVIEW AND REPORT.	SR	Ch. SL 2006-109	05-11-06	05-31-06
S1277=	Charlie S. Danne	NC NOVA-SPECIAL VOLUNTARY LICENSURE DESIGNAT.	*SR	Ch. SL 2006-104	05-11-06	06-08-06
S1278=	Charlie S. Danne	ADULT DAY AWARENESS/ STATUS OF STUDY RECOM.	SR	Ch. SL 2006-108	05-11-06	05-31-06
S1279=	Charlie S. Danne	REVIEW OF NC INSTITUTIONAL BIAS REPORT.	*SR	Ch. SL 2006-110	05-11-06	05-31-06
S1280=	Charlie S. Danne	DHHS EVALUATE TELEMON/ HOME CARE LICENSES.	*SR	Ch. SL 2006-194	05-11-06	06-22-06
$ S1288	**Don East**	**PHASE OUT MEDICAID COUNTY SHARE.**	**S**	**Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget**	**05-11-06**	
$ S1394=	**Jeanne H. Lucas**	**REPEAL COMM. COLL. MASSAGE PROG. EXEMPT/ STUDY.**	**S**	**Ref To Com On Health Care**	**05-16-06**	
S1487	Martin L. Nesbit	DENTAL HYGIENE LAW CHANGES.	*SR	Ch. SL 2006-235	05-18-06	06-14-06
S1529	Martin L. Nesbit	STRENGTHEN LOC	S	Ref To Com On	05-18-06	

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2005-2006 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		OVERSIGHT ROLE.		Health Care		
S1530	Martin L. Nesbit	STRENGTHEN STATE MH/ DD/SA REFORM.	S	Ref To Com On Health Care	05-18-06	
S1531	Martin L. Nesbit	STRENGTHEN LOCAL MANAGEMENT ENTITIES (LMES).	S	Ref To Com On Health Care	05-18-06	
S1956	William R. Purce	MEDICAID DRUG REIMBURSEMENT CHANGES.	S	Ref To Com On Health Care	05-25-06	

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AGENDA

SENATE HEALTH CARE COMMITTEE
May 17, 2006, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bills to be Considered

- **SB 1210 Repeal Eye Exam Requirement for Kindergarten Sen. Boseman**
- **HB 1330 Amend Electrolysis Practice Act/Fees Rep. Jeffus**

IV Other Business

V. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

CORRECTED REPORT

Thursday, May 18, 2006

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

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

S.B. **1210** Repeal Eye Exam Requirement for Kindergarten.

Draft Number:	PCS85402-SQ-49
Sequential Referral:	None
Recommended Referral:	Appropriations/Base Budget
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 3, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #3) **1330** Amend Electrolysis Practice Act/Fees.

Draft Number:	PCS60703-LU-12
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, May 17, 2006
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 17, 2006, in Room 544 of the Legislative Office Building, with eleven members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senate Bill 1210, *Repeal Eye Exam Requirement for Kindergarten*

Senator Purcell introduced Senator Boseman, who spoke on SB 1210, *Repeal Eye Exam Requirement for Kindergarten*. A motion for acceptance of a Proposed Committee Substitute was introduced, seconded by Senator Forrester, and passed. Shawn Parker of the Research Staff explained that the PCS makes two technical corrections and that this bill would repeal the requirement of the comprehensive eye examination, disband the Governor's Commission on Early Childhood Vision Care, abolish the Governor's Vision Care program, and revert funds appropriated for the program back to the General Fund. Senator Boseman said that this bill came about because many parents, children's advocates, and school boards feel that that this bill creates an unnecessary and unneeded financial burden on North Carolina's families. She pointed out that 87 school boards have sued to stop this requirement, and that a state superior court judge has issued a preliminary injunction to stop this from taking effect until June 30, 2007 (Attachment IV). Health checks given to pre-kindergarten children already include vision screenings, and if a problem is discovered, the child is referred to a vision specialist. Senator Lucas asked if any money appropriated for implementation of the Eye Exam Requirement has been spent, and if so, how much money would be reverted to the General Fund. Mr. Parker responded that of the $2 million appropriated none has been used. Senator Lucas observed that if this bill is passed, none of these funds would be used. Mr. Parker responded, "yes".

Senator Purcell asked Dr. Hal C. Herring, Jr., Optometrist and President of the North Carolina State Optometric Society for his comments (Attachment I). Dr. Herring asked permission to give the members a copy of a brochure entitled "Opening Eyes" (Attachment II). Senator Goodall asked Dr. Herring if there are any current members of the General Assembly who are either board members or trustees of his Society. Dr. Herring responded that Dr. Jim Black, Speaker of the North Carolina House, is a trustee of the North Carolina Optometric Society Board. Dr. Herring introduced Dr. Steven Eyler, optometrist and past president of the North Carolina State Board of Optometry Examiners, and currently serving as President of the National Board of Optometry Examiners. He introduced Mrs. Crystal Wilson and her daughter Sharese, a patient, whom he diagnosed with amblyopia; and echoed Dr. Herring's comments on the need for comprehensive eye exams, (Attachment III).

Dr. Peter Morris, President of the North Carolina Pediatric Society, practicing podiatrist, and specialist in pediatric epidemiology spoke. He said that the current vision screening program is adequate for picking up potential vision problems and that this viewpoint is endorsed by both pediatricians and optometrists. Dr. Bill Young, pediatric ophthalmologist, also spoke in favor of this bill. Senator Berger asked if Dr. Herring's claim that 30 to 60 percent of eye problems in school age children is missed, and if accurate, if it is an acceptable failure rate. Dr. Young responded that these figures came from an NIH study which included all types of eye problems, including near-sightedness as well as the significant eye problems. Senator Hartsell asked if there have been any studies comparing incidence of eye problems in North Carolina children of similar ages as opposed to those in surrounding states. Drs. Morris and Young responded that they were not aware of any. Dr. Ann Denlinger, Superintendent of Durham Public Schools, spoke of behalf of the North Carolina Association of School Administrators, the North Carolina School Boards Association, the North Carolina School Superintendents Association, and the North Carolina Principals and Assistant Principals Association. She

pointed out that the North Carolina Constitution and the 2005 law mandating comprehensive eye exams are in direct conflict in that this might bar some students from receiving a public education because of the $100 to $150 cost of this exam. She asked the committee members to vote in favor of Senator Bozeman's bill. The vote was called, and the bill passed, with a referral to the Appropriations Committee. (It was later determined in session that the bill need not be referred to Appropriations, and a request was made that it be calendared for the following session.)

Senate Bill 1330, *Amend Electrolysis Practice Act/Fees*

Senator Purcell brought the Proposed Committee Substitute for SB 1330, *Amend Electrolysis Practice Act/Fees* to the committee's attention. Senator Lucas so moved and the motion passed. Senator Purcell asked Ben Popkin of the Research staff to explain the PCS to the committee. This PCS would require that applicants for licensure as anesthesiology assistants be of good moral character and meet requirements as set by the North Carolina Medical Board, set a cap on the annual fee for registration and licensure to be no greater than $150, supervision by a licensed anesthesiologist, insert a new section restricting title of anesthesiologist assistant to only those persons licensed under GS 90-11, and direct the North Carolina Medical Board to adopt rules necessary to implement this section of the Statutes. Sherry Owens, past president of the North Carolina Association of Nurse Anesthetists and certified nurse anesthetist spoke against the bill, stating that there is no shortage of certified nurse anesthetists, and that anesthesiology assistants are not as highly trained and must work under the supervision of a licensed anesthetist. Senator Purcell recognized Mr. Jimmy Hicks, past president of the North Carolina Association of Nurse Anesthetists, and a nurse anesthetist, who also spoke against the bill. Dr. Tom Hill, president-elect of the North Carolina Society of Anesthesiologists and practicing anesthesiologist, spoke in favor of the bill, as did Dr. Nell, past president of the same Society. Meg O'Neal, a practicing anesthesiology assistant, spoke next, citing the need to go out of state for employment, which this bill would address, showing the need for passage of this bill. Senator Bingham said that it is his understanding that 35 counties have no coverage. Dr. Hill told him that in the past two years there were 18 hospitals that did not have anesthesiologists, mostly in the eastern part of the state, as well as some in the western part, although that has now been reduced to 14. Twenty of the 35 counties do not have a hospital, and that patients from those areas commute to a hospital in an urban area. Senator Bingham asked about the training of the Physician Assistants moving into the AA positions. Dr. Hill said that they must go through the training mentioned above. Senator Forrester moved for a favorable report for the PCS. The motion passed and the bill has a sequential referral to the Finance Committee.

The meeting adjourned at 12:15 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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 2

SENATE BILL 1210

Health Care Committee Substitute Adopted 5/18/06

Short Title: Repeal Eye Exam Requirement for Kindergarten. (Public)

Sponsors:

Referred to:

May 10, 2006

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE MANDATE THAT CHILDREN ENTERING KINDERGARTEN OBTAIN A COMPREHENSIVE EYE EXAMINATION, THE GOVERNOR'S VISION CARE PROGRAM, AND THE GOVERNOR'S COMMISSION ON EARLY CHILDHOOD VISION CARE; AND TO PROVIDE THAT FUNDS APPROPRIATED TO THE RESERVE FOR THE GOVERNOR'S VISION CARE PROGRAM SHALL REVERT TO THE GENERAL FUND.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.59F of S.L. 2005-276, as amended by Section 20 of S.L. 2005-345, and Part 35 of Article 3 of Chapter 143B of the General Statutes are repealed.

SECTION 2. Effective June 30, 2006, funds in the Reserve for the Governor's Vision Care Program shall revert to the General Fund.

SECTION 3. Except as otherwise provided in this act, this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1210

Short Title:	Repeal Eye Exam Requirement for Kindergarten.	(Public)
Sponsors:	Senators Boseman, Snow; Malone, Purcell, and Rand.	
Referred to:	Health Care.	

May 10, 2006

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE MANDATE THAT CHILDREN ENTERING KINDERGARTEN OBTAIN A COMPREHENSIVE EYE EXAMINATION, THE GOVERNOR'S VISION CARE PROGRAM, AND THE GOVERNOR'S COMMISSION ON EARLY CHILDHOOD VISION CARE; AND TO PROVIDE THAT FUNDS APPROPRIATED TO THE RESERVE FOR THE GOVERNOR'S VISION CARE PROGRAM SHALL REVERT TO THE GENERAL FUND.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.59F of S.L. 2005-276, as amended by Section 20 of S.L. 2005-345, and Part 34 of Article 3 of Chapter 143B of the General Statutes are repealed.

SECTION 2. Effective June 30, 2006, funds in the Reserve for the Governor's Vision Care Program shall revert to the General Fund.

SECTION 3. Except as otherwise provided in this act, this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1210
PROPOSED COMMITTEE SUBSTITUTE S1210-CSSQ-49 [v.1]

5/16/2006 9:57:06 AM

Short Title: Repeal Eye Exam Requirement for Kindergarten. (Public)

Sponsors:

Referred to:

May 10, 2006

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE MANDATE THAT CHILDREN ENTERING KINDERGARTEN OBTAIN A COMPREHENSIVE EYE EXAMINATION, THE GOVERNOR'S VISION CARE PROGRAM, AND THE GOVERNOR'S COMMISSION ON EARLY CHILDHOOD VISION CARE; AND TO PROVIDE THAT FUNDS APPROPRIATED TO THE RESERVE FOR THE GOVERNOR'S VISION CARE PROGRAM SHALL REVERT TO THE GENERAL FUND.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.59F of S.L. 2005-276, as amended by Section 20 of S.L. 2005-345, and Part 35 of Article 3 of Chapter 143B of the General Statutes are repealed.

SECTION 2. Effective June 30, 2006, funds in the Reserve for the Governor's Vision Care Program shall revert to the General Fund.

SECTION 3. Except as otherwise provided in this act, this act is effective when it becomes law.

SENATE BILL 1210:
Repeal Eye Exam Requirement for Kindergarten

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 16, 2006
Introduced by:	Sen. Boseman	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S1210-CSSQ-49		Legislative Analyst

SUMMARY: Senate Bill 1210 would repeal the requirement of all children entering kindergarten in the public schools to obtain a comprehensive eye exam. The bill also repeals the establishment of the Governor's Commission on Early Childhood Vision Care and, effective June 30, 2006, revert funds appropriated to the Commission to the General Fund. The remainder of this bill would become effective when it becomes law.

The PCS makes a technical correction to conform with changes made at the direction of the Revisor of Statutes.

CURRENT LAW: Section 10.59F of Session Law 2005-276, the Appropriations Act, established the Governor's Vision Care Program and required for every child in the State entering kindergarten in the public schools to obtain a comprehensive eye examination conducted by a licensed optometrist or ophthalmologist. This section was later revised in Section 20 of Session Law 2005-345 to make technical changes and adjust a reporting date.

The comprehensive eye exam consists of a complete and thorough examination of the eye and human visual system and includes an evaluation, determination, and diagnosis of:

- Visual acuity at a distance and near
- Alignment and ocular motility
- Actual refractive errors
- Any color vision disorder
- Intraocular pressure
- Ocular health, including internal and external assessment

The Governor's Vision Care Program provides funds for eligible children in grades K-3 to reimburse optometrist and ophthalmologist for the comprehensive examination, including necessary spectacles. The Program is located in the Department of Health and Human Services, Division of Public Health and is administered by the Governor's Commission on Early Childhood Vision Care, a six member commission comprised of three optometrist and three ophthalmologist appointed by the Governor, The Speaker of the House, and the President Pro Tempore of the Senate.

BILL ANALYSIS: Senate Bill 1210 would abolish the Governor's Vision Care Program, abolish the Commission on Early Childhood Vision Care, would repeal the requirement of a comprehensive examination of children entering kindergarten in the public schools, and effective June 20, 2006, funds appropriated to the Reserve for the Governor's Vision Care Program would revert to the General Fund.

Attachment I

SUPPORT FOR THE GOVERNOR'S CHILDREN'S VISION CARE PROGRAM

I am Hal Herring, current President of the North Carolina State Optometric Society, and I have practiced Optometry in Fairmont, NC for the past 31 years. I would like to thank the committee for allowing me to speak today in support of the Governor's Children's Vision Care Program, and I would also thank those who took the time to read the information I sent in February on the merits of preschool eye exams. I realize that I may be one of the few people in this room in favor of keeping the children's vision law; however, it concerns me deeply that a requirement that has such potential benefit for North Carolina's children faces repeal based on politics rather than on a scientific study of its merits.

There is abundant scientific data that indicates that comprehensive eye exams for preschoolers are a better way to ensure the visual welfare of children and their readiness to learn. States throughout the nation have either passed or are considering legislation to require these exams. In 2000, Kentucky was the first state to require comprehensive eye exams for all children entering school. North Carolina and Puerto Rico followed, passing similar laws, and Oklahoma will vote on their children's vision law within weeks. Arkansas, Rhode Island, Massachusetts, and Ohio also require enhanced screening exams before starting school, with mandatory comprehensive exams for those who fail the screening. Nationally, Congress recognizes the importance of eye exams for our children, and current legislation before the house (HR2238) with 190 cosponsors that include six representatives from North Carolina, would provide $75 million in grant monies to states requiring preschool exams. North Carolina's share would amount to $1.5 to $2 million.

This is not a North Carolina political issue; it is a national public health issue, and repeal of this law will result in significant and permanent injury to the children of North Carolina.

- 80% of learning in the first 12 years of life comes through our eyes, yet 86% of this age group has never had an eye exam.
- There is reliable evidence that our current system of screenings is inadequate. The Vision in Preschoolers Study by the National Eye Institute revealed that screenings miss 30% to 60% of eye problems in school-aged children. Amblyopia or "lazy eye," a condition in which one eye does not develop normal vision, is preventable in most children if caught before age 6. However, amblyopia results in permanent vision loss if not addressed by age 9 or 10. From 2% to 5% of school-age children are affected by amblyopia and are frequently missed by the screening process until it is too late to fix the problem. In North Carolina that is 2 to 5 thousand children each year that may have permanent vision loss because they were missed by our screening system. Is that an acceptable number? I think you would agree with me that it is not, especially if one of those was your own child. We have an opportunity to eliminate preventable amblyopia in North Carolina if we retain the Children's Vision law.

Opponents of this law have said that it is too expensive and unconstitutional since we will be requiring a parent to pay for an eye exam to have their child admitted to public school. Kentucky's experience indicates the cost to the state to be minimal. In the first five years of their program, they spent less than $10 thousand per year to pay for exams for those who

were financially disadvantaged. Our current law set aside $2 million to help pay for exams for needy children who do not qualify for other assistance programs.

Optometrists in North Carolina are committed to the success of this program. We are willing to do whatever it takes to make sure every child has access to appropriate eye and vision care prior to their entering the public school systems of North Carolina. If a parent feels their constitutional rights are being violated by this requirement, we pledge to find a way to obtain an eye exam for their child at no cost to them.

I urge you to examine Kentucky's experience with required comprehensive eye exams for preschoolers. They have no opposition from legislators, parents or school officials to the requirement. In fact, all of those groups are now enthusiastic supporters of their law. Bill Scott, Executive Director of the Kentucky School Boards Association, states in a letter to his congressman, the Honorable Ben Chandler, "Our model of requiring every child entering public schools for the first time to have an eye examination by an optometrist or ophthalmologist no later than January 1st of the school year is one that you may want to bring forth for replication in every state. Your support of this and all children's vision initiatives will ensure that far fewer children fall behind and many more children enjoy the academic opportunities that promise them a prosperous future."

In summary:

- Children's vision exams are a national public health issue, not a North Carolina political issue.
- Our current system of vision screenings is inadequate to catch all vision problems in our children, and if left in place will result in irreversible vision loss for 2 to 5 thousand of our children each year from preventable amblyopia.
- Experience in Kentucky indicates mandatory eye exams for preschoolers are effective and affordable.
- North Carolina optometrists are committed to this program, and will continue to be advocates for the visual well being of North Carolina's children. This is not an issue that will "go away" if this law is repealed.

Thank you for your attention, and for your service to the citizens of North Carolina. Please take time to read the accompanying information which supports the findings that I have mentioned, and please feel free to contact me with questions.

Respectfully submitted,

Hal C. Herring Jr. OD

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NORTH CAROLINA STATE OPTOMETRIC SOCIETY
STATEMENT IN OPPOSITION TO SB 1210

There are more than 570,000 children under the age of 5 in North Carolina[1]. According to numerous medical studies, between 2% and 5% of them have a condition known as amblyopia, the leading cause of permanent vision loss in young Americans.

Amblyopia is a serious vision disorder and requires early detection and treatment to avoid permanent vision loss. Yet sadly, the medical literature also shows that 30%-50% of children are not tested for amblyopia as recommended by the American Academy of Pediatrics.

Even those children who get tested are still at risk. The landmark VIP study by the National Institutes of Health found that the vision tests used in pediatricians' offices missed 40%-60% of children with an eye problem.[4] Additional studies have shown that when a child's problem is caught, as many as 2/3 don't visit the eye doctor as recommended.[5]

As a result, thousands of children in North Carolina have an undetected or untreated vision problem that can lead to permanent vision loss. Sadly, we've known this for a long time. In February 1995, a NC Department of Health task force of nurses, family physicians, pediatricians, ophthalmologists and an educator concluded that:

> North Carolina's vision screening program...has weaknesses that significantly impair its effectiveness. Undetected and untreated vision deficiencies take a huge toll...in preventable medical expenditures...special education programs, lost wages and productivity, and preventable social welfare spending

In order to address this problem, the group stated the following:

> The Task Force expresses a strong consensus about the value of a comprehensive eye examination by an eyecare professional at age 3 with the primary focus on detection and treatment of amblyopia. The Task Force further concludes that if a comprehensive eye exam cannot be accomplished at age 3, it should be done as soon thereafter as possible.[6]

What a difference ten years makes.

Optometrists in the state of North Carolina were pleased to see the legislature take action last year in support of this issue. We were astonished to see the negative reaction from the medical, education and political communities.

Pediatricians, ophthalmologists and family physicians – all MDs - know full well the serious shortcomings of our vision screening program. Yet they've spoken out in violent opposition to this law and to the profession of optometry.

One publicly called us "technicians...untrained medically to treat diseases[7]" even though we have four years of post-graduate medical training, complete a minimum of 20 hours of medical education annually and have been licensed since the 1970s to medically treat and write prescriptions for all primary eye conditions.

Educators also know the impact of undetected and untreated vision problems in children. The National Head Start Association has endorsed legislation to increase the number of children that receive an eye exam while the National PTA has endorsed a resolution calling on all children to visit an eye doctor before starting school.

In Kentucky, one of seven states to enact a law requiring eye exams for children, educators were among the laws strongest supporters. Educators in New York and Boston have gone so far as to include eye doctors' offices in public schools. Yet in North Carolina, educators have sued to have the law repealed.

Political support has fallen as well. Some have decried the "extreme cost" of the law. Yet a study by the well-respected firm Abt Associates found eye exams for children to be extremely cost effective. Kentucky spends less than $10,000 per year to help families without insurance or who cannot afford an eye exam for their child.

Others have criticized the manner in which this law was enacted. But each year the legislature considers thousands of bills and enacts hundreds, some with dozens of provisions many of which presumably go unread and undebated by the legislature. There's a reason why legislating is compared to sausage-making: it's not a pretty sight.

But in this case it worked. We've known about this problem for years. We've done the right thing by requiring eye exams for children, regardless of the manner in which the law was enacted. It would be a grave injustice to repeal this law for political reasons when the public health reasons speak so strongly in its support.

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[6] *Report of the Task Force to Review Vision Screening,* NC Department of Environment, Health and Natural Resources, February 1995. Available online at www.spark-light.com/DEHNR.pdf

[7] Letter to the Editor, *Rocky Mount Telegram*, April 04, 2006.

EARLY CHILDHOOD VISION CARE PROGRAM

VALUE:

- It is currently the law and, despite the controversy over how it became law, all evidence indicates it is a good law and will greatly benefit the children of North Carolina.
- Eighty percent of what children learn is through vision.
- Approximately 10% of preschool children and 25% of school age children have undiagnosed vision problems according to statistics from the US Dept. of Health and Human Services and from the American Optometric Association.
- Currently only 14 to 20 percent of preschoolers receive a comprehensive eye exam prior to entering kindergarten.
- Vision screenings by pediatricians, school nurses, and other screening groups have some value; however, screenings have been proven ineffective in recognizing key eye and vision problems. The Vision in Preschoolers (VIP) study by the National Eye Institute found that even the best screenings performed by eye care professionals miss over 30% of children who should be referred for a comprehensive eye examination.
- There is a nationwide call for mandatory eye exams for children starting school. This call is coming from many sectors:
    1. Better Vision Institute: "A timely, comprehensive eye exam by a qualified eye care professional is key to discovering vision difficulties in children."
    2. Prevent Blindness America: "The best way to protect a child's eyes is through professional eye examinations...before entering school (age 4 or 5) and periodically throughout the school years."
    3. National PTA: "Early diagnosis and treatment of children's vision problems is a necessary component to school readiness and academic learning. Vision screening is not a substitute for a complete eye and vision evaluation by an eye doctor. Comprehensive eye and vision examinations by an optometrist or an ophthalmologist are important for all children first entering school and regularly throughout their school-aged years to ensure healthy eyes and adequate vision skills essential for successful academic achievement."
    4. The Department of Public Health, the American Optometric Association, and the American Foundation of Vision Awareness have issued similar statements.
- In 2000, Kentucky became the first state to pass a mandatory eye exam bill for children entering public school. Estimates from Kentucky show that mandated eye exams detected vision problems in approximately 20% of children.
- Undetected and untreated vision deficiencies are costly in both the short and the long term. Studies have shown that citizens who can neither read nor write at a level necessary to become productive citizens have a negative impact on society. While there are many factors that contribute to these individuals' deficits in learning, lack of proper vision care can be significant. Among the long-term costs are preventable medical expenditures, preventable welfare spending, and the misidentification of children with learning difficulties.
- Just as the North Carolina immunization requirements help protect the physical well-being of entering school children, a children's vision exam requirement is essential to protect the visual well-being of entering school children.
- Nationally, 186 members of Congress, including six congressmen representing communities across North Carolina, have co-sponsored bipartisan legislation (HR2238 now before Congress) that recognizes the importance of comprehensive eye exams for school-age children.

COSTS:

- According to a recent study by the US Department of Health and Human Services, the economic impact of visual disorders and disabilities on the US economy was more than 38.4 billion dollars per year.
- Comprehensive eye examinations are much less expensive when compared to the medical and social consequences of missed eye pathology and poor vision over the long term. Comprehensive eye exams are a wise investment in the future of North Carolina children.
- State funding is available for those who are not covered by private insurance and cannot afford the exams.
    1. North Carolina health departments have a listing of the many resources available for eye exams for financially disadvantaged families.
    2. The Early Childhood Vision Care Program set aside $2 million to help pay for exams for needy children that do not qualify for other assistance programs.
    3. Kentucky, the first state to pass mandatory children's vision exam legislation in 2000, found that very little of the money set aside for exams was used. In the first two years of their program, only 141 exams were paid for through the reserve fund.

ACCESS:

- With 1100 optometrists and approximately 475 ophthalmologists practicing in North Carolina, families have access to eye exams.
    1. Optometrists in North Carolina are committed to the successful implementation of the Early Childhood Vision Care Program and pledge to ensure access to convenient and affordable care for all people in our communities.
    2. Optometrists generally maintain convenient, family-friendly office hours including evenings and weekends, giving patients the opportunity to receive the care they need.

CONCLUSION:

Eye screenings in pre-school physicals and in vision screening programs, though having some value, are not a substitute for a professional eye examination. Thousands of North Carolina's children are at risk because of undiagnosed eye and vision disorders. The only way to prevent years of needless suffering and failure for these children is by early diagnosis through a comprehensive vision examination. Any undetected vision problem results in the reduction of efficiency of the visual system. This further results in the inability of children to achieve their full potential. Therefore, all children should receive a comprehensive eye and vision examination assessing and treating any deficiencies in ocular health, visual acuity, refractive status, ocular mobility, and binocular vision prior to entering school.

RESPONSES TO RECENT CRITICISM OF THE GOVERNOR'S CHILDREN'S VISION CARE PROGRAM

Opponents of this law say: "The current vision screening system works fine."

- According to the American Academy of Pediatrics, less than 50% of preschool age children are screened in pediatric practices.
- The Vision in Preschoolers (VIP) Study by the National Eye Institute showed that the best screenings by eye care professionals missed over 30% of children who should be referred for a comprehensive eye examination.
- 10% of preschoolers and 25% of school age children have undiagnosed vision problems, according to statistics from the Department of Health and Human Services and the Department of Health, Education and Welfare.
- Data from Kentucky, the first state to pass mandatory children's vision exam legislation in 2000, show that mandated eye exams detect vision problems in about 20% of children.
- If the current system was working, the incidence of amblyopia (a condition in which one eye does not develop normal vision, largely curable with early diagnosis) would not currently be 3 to 5 percent in our school age children.

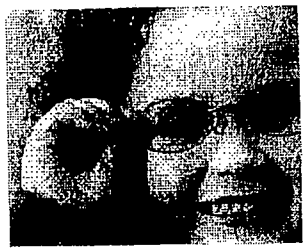
Opponents of this law say: "It is too costly for the parents."

- Comprehensive eye examinations are much less expensive when compared to the medical and social consequences of missed eye pathology and poor vision over the long term. According to a recent study by the U.S. Dept. of Health and Human Services, the economic impact of visual disorders and disabilities on the U.S. economy is more than 38.4 billion dollars per year.
- State funding is available for those not covered by private insurance and unable to afford the exams. The Governor's Children's Vision Care Program set aside $2 million to help pay for exams for needy children who do not qualify for other assistance programs.
- North Carolina has a vision referral system already in place in the local health departments. They have a list of the many resources available for eye exams for financially disadvantaged families (i.e. Medicaid, Blind Commission, Lion's Club, Vision USA, VSP Sight for Students).
- Kentucky found that very little of the money set aside for eye exams was used. In the first two years of their program, only 141 exams were paid through their reserve fund.

Opponents of the law say: "It is an administrative nightmare." "We cannot get all those children examined in time." "We cannot refuse a child admission to school because they have not had an eye exam."

- Children entering public school are currently required to have a physical exam and immunizations prior to admission. The comprehensive exam requirement would simply be added to a system that is already place. Certainly the benefits of having our children visually ready to learn when they enter kindergarten and the opportunity to eliminate amblyopia as a visual handicap would vastly outweigh any initial administrative inconvenience.
- With over 1000 optometrists and approximately 475 ophthalmologists practicing in North Carolina, families have adequate access to exams. If we have 100,000 entering kindergarteners yearly and 1500 providers, this gives an average of less than 70 exams per provider. Since the average provider would see 50 to 100 exams per week, this does not represent an overload for the system.
- The North Carolina State Optometric Society would favor a ruling that would extend the time period allowed for the exam to one year prior to starting school, with a grace period of 60 days following the start of the school year to allow those who did not receive a timely exam to meet the requirement after being enrolled. The exam could be obtained from any licensed optometrist or ophthalmologist.

READY FOR SCHOOL



VISION EXAMINATIONS FOR CHILDREN ENTERING SCHOOL

Why it works in Kentucky and should be enacted in other states

- The Kentucky General Assembly unanimously passed in 2000 the nation's first ever mandatory vision exam bill for children entering public schools.

- The legislation, identified as Kentucky's Early Childhood Development Initiative, is part of a statewide children's health initiative designed to ensure that children begin life in an environment that provides the care necessary to help ensure they will be successful learners when they enter school and become productive citizens as they grow up.

- Estimates from Kentucky suggest that the mandated eye exams detected vision problems in approximately 20 percent of children, resulting in early intervention for diseases and disorders such as amblyopia, or lazy eye, that must be treated at a young age before irreversible damage is done.

- Before the Kentucky law was enacted, the only vision evaluation requirement for children was a vision screening performed by the student's primary care physician during part of a regular school entrance physical. These simple screenings typically only measure distance vision, leaving many deficiencies, such as visual alignment, color vision, amblyopia or more serious pathology, undetected.

- According to the Kentucky Optometric Association, 10 percent of preschoolers have vision deficiencies and 25 percent of students in kindergarten through sixth grade have vision deficiencies.

- Based on a clinical survey conducted throughout the first year after the enactment of the Kentucky Eye Exam law, 5,316 children entering the school system for the first time were reviewed. The results revealed that approximately 14 percent of children needed corrective lenses; hundreds of children also were diagnosed with amblyopia, strabismus and other eye diseases.

- In addition to the hundreds of corrective lenses that were prescribed as a result of these exams, other serious eye problems such as ocular pathology, retinal detachment, conjunctivitis and even a brain tumor were discovered.

- The state originally set aside $150,000 per year for children not eligible for other programs and for those without private insurance coverage. In addition, optometrists, ophthalmologists and local charity organizations provide ongoing assistance for families in need.

- In the first two years of the program, only 141 total exams were paid for under this reserve fund. Due to the lack of need and underutilization of the funding program, the state was able to reduce the allocation to $50,000 from the original $150,000.

- When comprehensive vision exams are mandated many severe eye and vision problems that might otherwise go undetected are diagnosed and treated. With this law in place, these dangerous and potentially blinding problems may be avoided and children will be able to begin their education with optimum eyesight and a fuller chance to succeed.

American Optometric Association

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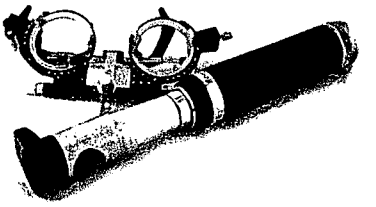
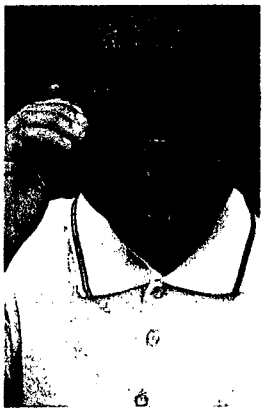
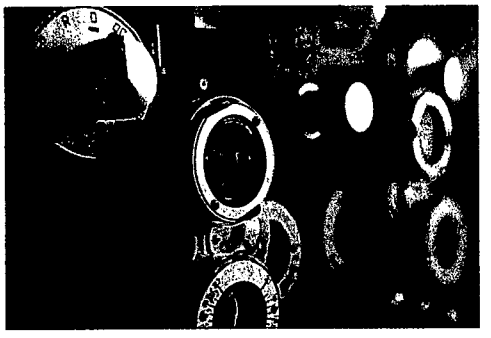
Attachment II

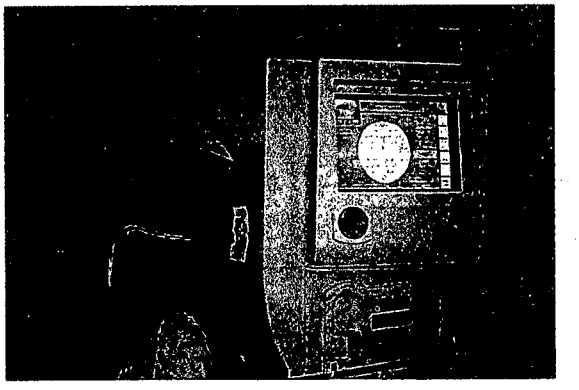
OPENING EYES







The Merits and Successes of Child Eye Examinations



Support For the North Carolina Children's Vision Law

Images from Agency: Dreamstime.com

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IV. On Solid Ground:
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I. Seeing the Benefits: Merits of the Governor's Children's Vision Care Program

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[5] Preslan and Novak, *Ophthalmology*, Volume 105, pp. 150-153

[6] *Report of the Task Force to Review Vision Screening,* NC Department of Environment, Health and Natural Resources, February 1995. Available online at www.spark-light.com/DEHNR.pdf

[7] Letter to the Editor, *Rocky Mount Telegram*, April 04, 2006.

EARLY CHILDHOOD VISION CARE PROGRAM

VALUE:

- It is currently the law and, despite the controversy over how it became law, all evidence indicates it is a good law and will greatly benefit the children of North Carolina.
- Eighty percent of what children learn is through vision.
- Approximately 10% of preschool children and 25% of school age children have undiagnosed vision problems according to statistics from the US Dept. of Health and Human Services and from the American Optometric Association.
- Currently only 14 to 20 percent of preschoolers receive a comprehensive eye exam prior to entering kindergarten.
- Vision screenings by pediatricians, school nurses, and other screening groups have some value; however, screenings have been proven ineffective in recognizing key eye and vision problems. The Vision in Preschoolers (VIP) study by the National Eye Institute found that even the best screenings performed by eye care professionals miss over 30% of children who should be referred for a comprehensive eye examination.
- There is a nationwide call for mandatory eye exams for children starting school. This call is coming from many sectors:
    1. Better Vision Institute: "A timely, comprehensive eye exam by a qualified eye care professional is key to discovering vision difficulties in children."
    2. Prevent Blindness America: "The best way to protect a child's eyes is through professional eye examinations...before entering school (age 4 or 5) and periodically throughout the school years."
    3. National PTA: "Early diagnosis and treatment of children's vision problems is a necessary component to school readiness and academic learning. Vision screening is not a substitute for a complete eye and vision evaluation by an eye doctor. Comprehensive eye and vision examinations by an optometrist or an ophthalmologist are important for all children first entering school and regularly throughout their school-aged years to ensure healthy eyes and adequate vision skills essential for successful academic achievement."
    4. The Department of Public Health, the American Optometric Association, and the American Foundation of Vision Awareness have issued similar statements.
- In 2000, Kentucky became the first state to pass a mandatory eye exam bill for children entering public school. Estimates from Kentucky show that mandated eye exams detected vision problems in approximately 20% of children.
- Undetected and untreated vision deficiencies are costly in both the short and the long term. Studies have shown that citizens who can neither read nor write at a level necessary to become productive citizens have a negative impact on society. While there are many factors that contribute to these individuals' deficits in learning, lack of proper vision care can be significant. Among the long-term costs are preventable medical expenditures, preventable welfare spending, and the misidentification of children with learning difficulties.
- Just as the North Carolina immunization requirements help protect the physical well-being of entering school children, a children's vision exam requirement is essential to protect the visual well-being of entering school children.
- Nationally, 186 members of Congress, including six congressmen representing communities across North Carolina, have co-sponsored bipartisan legislation (HR2238 now before Congress) that recognizes the importance of comprehensive eye exams for school-age children.

COSTS:

- According to a recent study by the US Department of Health and Human Services, the economic impact of visual disorders and disabilities on the US economy was more than 38.4 billion dollars per year.
- Comprehensive eye examinations are much less expensive when compared to the medical and social consequences of missed eye pathology and poor vision over the long term. Comprehensive eye exams are a wise investment in the future of North Carolina children.
- State funding is available for those who are not covered by private insurance and cannot afford the exams.
    1. North Carolina health departments have a listing of the many resources available for eye exams for financially disadvantaged families.
    2. The Early Childhood Vision Care Program set aside $2 million to help pay for exams for needy children that do not qualify for other assistance programs.
    3. Kentucky, the first state to pass mandatory children's vision exam legislation in 2000, found that very little of the money set aside for exams was used. In the first two years of their program, only 141 exams were paid for through the reserve fund.

ACCESS:

- With 1100 optometrists and approximately 475 ophthalmologists practicing in North Carolina, families have access to eye exams.
    1. Optometrists in North Carolina are committed to the successful implementation of the Early Childhood Vision Care Program and pledge to ensure access to convenient and affordable care for all people in our communities.
    2. Optometrists generally maintain convenient, family-friendly office hours including evenings and weekends, giving patients the opportunity to receive the care they need.

CONCLUSION:

Eye screenings in pre-school physicals and in vision screening programs, though having some value, are not a substitute for a professional eye examination. Thousands of North Carolina's children are at risk because of undiagnosed eye and vision disorders. The only way to prevent years of needless suffering and failure for these children is by early diagnosis through a comprehensive vision examination. Any undetected vision problem results in the reduction of efficiency of the visual system. This further results in the inability of children to achieve their full potential. Therefore, all children should receive a comprehensive eye and vision examination assessing and treating any deficiencies in ocular health, visual acuity, refractive status, ocular mobility, and binocular vision prior to entering school.

RESPONSES TO RECENT CRITICISM OF THE GOVERNOR'S CHILDREN'S VISION CARE PROGRAM

Opponents of this law say: "The current vision screening system works fine."

- According to the American Academy of Pediatrics, less than 50% of preschool age children are screened in pediatric practices.
- The Vision in Preschoolers (VIP) Study by the National Eye Institute showed that the best screenings by eye care professionals missed over 30% of children who should be referred for a comprehensive eye examination.
- 10% of preschoolers and 25% of school age children have undiagnosed vision problems, according to statistics from the Department of Health and Human Services and the Department of Health, Education and Welfare.
- Data from Kentucky, the first state to pass mandatory children's vision exam legislation in 2000, show that mandated eye exams detect vision problems in about 20% of children.
- If the current system was working, the incidence of amblyopia (a condition in which one eye does not develop normal vision, largely curable with early diagnosis) would not currently be 3 to 5 percent in our school age children.

Opponents of this law say: "It is too costly for the parents."

- Comprehensive eye examinations are much less expensive when compared to the medical and social consequences of missed eye pathology and poor vision over the long term. According to a recent study by the U.S. Dept. of Health and Human Services, the economic impact of visual disorders and disabilities on the U.S. economy is more than 38.4 billion dollars per year.
- State funding is available for those not covered by private insurance and unable to afford the exams. The Governor's Children's Vision Care Program set aside $2 million to help pay for exams for needy children who do not qualify for other assistance programs.
- North Carolina has a vision referral system already in place in the local health departments. They have a list of the many resources available for eye exams for financially disadvantaged families (i.e. Medicaid, Blind Commission, Lion's Club, Vision USA, VSP Sight for Students).
- Kentucky found that very little of the money set aside for eye exams was used. In the first two years of their program, only 141 exams were paid through their reserve fund.

Opponents of the law say: "It is an administrative nightmare." "We cannot get all those children examined in time." "We cannot refuse a child admission to school because they have not had an eye exam."

- Children entering public school are currently required to have a physical exam and immunizations prior to admission. The comprehensive exam requirement would simply be added to a system that is already place. Certainly the benefits of having our children visually ready to learn when they enter kindergarten and the opportunity to eliminate amblyopia as a visual handicap would vastly outweigh any initial administrative inconvenience.
- With over 1000 optometrists and approximately 475 ophthalmologists practicing in North Carolina, families have adequate access to exams. If we have 100,000 entering kindergarteners yearly and 1500 providers, this gives an average of less than 70 exams per provider. Since the average provider would see 50 to 100 exams per week, this does not represent an overload for the system.
- The North Carolina State Optometric Society would favor a ruling that would extend the time period allowed for the exam to one year prior to starting school, with a grace period of 60 days following the start of the school year to allow those who did not receive a timely exam to meet the requirement after being enrolled. The exam could be obtained from any licensed optometrist or ophthalmologist.

READY FOR SCHOOL

VISION EXAMINATIONS FOR CHILDREN ENTERING SCHOOL

Why it works in Kentucky and should be enacted in other states

- The Kentucky General Assembly unanimously passed in 2000 the nation's first ever mandatory vision exam bill for children entering public schools.

- The legislation, identified as Kentucky's Early Childhood Development Initiative, is part of a statewide children's health initiative designed to ensure that children begin life in an environment that provides the care necessary to help ensure they will be successful learners when they enter school and become productive citizens as they grow up.

- Estimates from Kentucky suggest that the mandated eye exams detected vision problems in approximately 20 percent of children, resulting in early intervention for diseases and disorders such as amblyopia, or lazy eye, that must be treated at a young age before irreversible damage is done.

- Before the Kentucky law was enacted, the only vision evaluation requirement for children was a vision screening performed by the student's primary care physician during part of a regular school entrance physical. These simple screenings typically only measure distance vision, leaving many deficiencies, such as visual alignment, color vision, amblyopia or more serious pathology, undetected.

- According to the Kentucky Optometric Association, 10 percent of preschoolers have vision deficiencies and 25 percent of students in kindergarten through sixth grade have vision deficiencies.

- Based on a clinical survey conducted throughout the first year after the enactment of the Kentucky Eye Exam law, 5,316 children entering the school system for the first time were reviewed. The results revealed that approximately 14 percent of children needed corrective lenses; hundreds of children also were diagnosed with amblyopia, strabismus and other eye diseases.

- In addition to the hundreds of corrective lenses that were prescribed as a result of these exams, other serious eye problems such as ocular pathology, retinal detachment, conjunctivitis and even a brain tumor were discovered.

- The state originally set aside $150,000 per year for children not eligible for other programs and for those without private insurance coverage. In addition, optometrists, ophthalmologists and local charity organizations provide ongoing assistance for families in need.

- In the first two years of the program, only 141 total exams were paid for under this reserve fund. Due to the lack of need and underutilization of the funding program, the state was able to reduce the allocation to $50,000 from the original $150,000.

- When comprehensive vision exams are mandated many severe eye and vision problems that might otherwise go undetected are diagnosed and treated. With this law in place, these dangerous and potentially blinding problems may be avoided and children will be able to begin their education with optimum eyesight and a fuller chance to succeed.

American Optometric Association

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SAINT LOUIS, MISSOURI 63141
314.991.4100 F. 314.991.4101 | AOA.ORG

II. Helping Those in Need:
Parent Testimonials

UNIVERSITY EYE ASSOCIATES
Doctors of Optometry, P.A.

Dr. Steven H. Eyler
Dr. Kenneth W. Best
Dr. Magda M. Metwalli
Dr. Kristin N. Richwine
Dr. Robert C. Hamp
Dr. N. Elaine Osborne

March 15, 2006

Re: Ms. Charisse Balem
Age 4.5 years

Here is a letter I received from a mother of a pre-kindergartner who brought her daughter in for a complete vision examination after hearing that North Carolina was one of two states in the country that had a new law requiring all entering kindergartners to be examined by an optometrist or ophthalmologist before starting elementary school. Please carefully consider this child, and the hundreds of other children that will be diagnosis and properly treated, if the new " NC kids vision bill" is kept in place. The money that will be saved by the tax - payers of North Carolina with early, appropriate treatment of these potentially learning disabled children, will only supplement their 'quality-of-life' potential realized by professional, medical-eye care intervention.

Respectively Submitted,

Steven H. Eyler, O.D., F.A.A.O..
President, National Board of Examiners in Optometry

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Fax 704-548-8017

HICKORY GROVE OFFICE
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704-536-6042
Fax 704-563-5917

DAVIDSON OFFICE
455 South Main Street, Suite 100
Davidson, NC 28036
704-896-9090
Fax 704-896-9680

March 14, 2006

Dear Member of North Carolina General Assembly:

I have a 4-½ year old daughter that wears glasses.

My daughter Charisse Balem had her 4-year-old well visit in the fall of 2005. Her pediatrician said I had the option of getting her eyes checked at this visit or I could wait until her next year's checkup at the age of 5 before she started kindergarten. I requested her eyes to be checked at this well visit. She passed with flying colors and I was told there were no issues with her eyes or vision. I am fortunate enough to have vision insurance, however, and with the start of the new 2006 year I decided to schedule eye exams for all of us, 2 year old daughter and 4 year old daughter included, especially since my 4 year old would be starting kindergarten this year. I did not suspect there would be any issues at all but even though my daughter's pediatrician said her eyes were fine, I felt an eye exam by a qualified eye doctor would not hurt.

Imagine my concern when I find that my daughter is farsighted with astigmatism, has 20/80 vision in one eye that happens to also be lazy and 20/50 vision in the other eye! I was just told a few months earlier by her pediatrician that her vision was fine. Her eye doctor prescribed eye glasses for her and told me that had I not brought her in at this time that a lazy eye would have been almost impossible to correct at a later age. I was very thankful in my foresight that I had decided to take my daughters to see an eye doctor. Her vision a year later could have worsened to the point of a visible lazy eye and possible delays in her reading and learning development.

I recently read an article that nearly a dozen local school boards are suing the state of NC over a new law requiring comprehensive eye exams for children entering kindergarten, arguing it violates the state constitution's mandate for free public education and it would be too expensive and unnecessary. I am dismayed that this law may not go into effect because of the costs of an exam. What about parents such as myself who have vision insurance but may not know the risks of waiting too long to take a child for an eye exam? The $65- 120 would be worth it to me to find a way to pay regardless if I had insurance or not to prevent my child from having visions problems such as 20/80 vision and a lazy eye that could affect her ability to read, learn and her quality of life. Do we want schools full of children who maybe not learning as well as they should not because they have ADD or some other developmental disorder but because they simply don't see well enough, a problem that could be addressed corrected by means of a mandatory eye exam before beginning kindergarten? If not at kindergarten for this expense, then when, for those with vision issues?

My daughter would get very frustrated when we would practice recognizing her letters and numbers and reading stories. I thought it was just because she was 4 and being contrary. But I found out that it could have been that she simply could not see letters and numbers and books clearly. In two weeks since receiving her new glasses, her vision has improved dramatically. I am so thankful for my eye doctor helping me to address my daughter's vision problems now instead of sadly finding out a year or two from now that a lazy eye could not be corrected. I sincerely hope that NC will reconsider this law.

Respectfully yours,

Crystal Wilson

Crystal Wilson
440 Riverglen Drive NW
Concord, NC 28027

2/3/06

To Whom It May Concern

I am writing this letter in regards to my son Charlie and the new law that they are trying to get in effect for children to get an eye exam prior to starting school.

My son Charlie began his kindergarten year just like any other 5 year old. We were blessed with a teacher that had the ability to see and predicate many things. In mid-October she approached me she said that she thought Charlie might have something wrong with his eyes. She recommended Dr. Cathy Doty as a eye doctor to go she because she had helped her son with his own eyesight and they had made great progress. Sure enough, once the exam was complete Charlie's right eye was a 20/80 and his left eye was an 20/400. Imagine my surprise. He had had the basic tests at the doctors office right before his beginning school and none of this was brought to our attention.

For about 2 years Dr. Doty, Charlie and I worked very hard to try to correct his eyesight. From patching the left eye to going to Raleigh for tests to make sure there was nothing wrong that we could not see, my son has been left with some serious permanent eye damage in his left eye. His right eye has been corrected but the left eye is hanging tough at a 20/100. It will never be any better. That is a shame that such a wonderful child lost some of his eyesight. If only this law had been put in place when Charlie was coming up this could have been prevented, but we will never know. Those tests they give at the doctor's office are not complete enough to catch anything major and each child should be given an opportunity to be successful adult. Lord knows, life is tough enough without adding a hindrance.

Just some words from mother who has fought the fight. Good luck and I hope the law has the ability to go into effect. From a teacher's stand point, it could make the whole difference in a child's life.

Sincerely,
Kathleen Henderson

To Whom It May Concern:

I am thrilled to think that all children will have their vision tested before entering Kindergarten. I think that this will actually be a gift to many children, though I know that for some the expense may seem unnecessary. It is very necessary. I'd like to share my story...

I have two boys who are two years a part. My youngest is always trying to keep up with my oldest, in everything. My youngest, Brandon has always been energetic, enthusiastic and moving. Sitting still for a story, coloring, painting, cutting was always a challenge for him. His Preschool teacher half-jokingly warned me that his Kindergarten teacher might want him tested for ADD. He was not a behavioral problem, he just was not "able" to focus on "school work". Fortunately, Brandon had a fantastic Kindergarten teacher who had the patience of a Saint and continuously encouraged Brandon to take his time, slow down, and have patience because he did have the ability to do well. He desperately wanted to read in Kindergarten, just like his brother. He worked hard at school and at home. By Christmas time he was holding his head and complaining of terrible headaches, but he was reading beautifully.

Brandon had passed the vision screening and been to the doctors regularly. The headaches and complaining continued so I took him to the Pediatrician. They looked at everything, including his eyes and could find no reason for his complaint. Brandon went through a tremendous amount of blood work, because they were looking for an answer. They were concerned about cancer, tumours and all kinds of horrors that I imagined. After two months of agony and no answers and now he was rubbing his head and holding his eyes open with his fingers to see, they suggested a CAT scan. I was petrified and decided instead to get him in to see an eye Doctor that I trusted, just in case it was very serious and we needed more opinions. My children are the most important thing in the world and it pained me greatly to see one suffer for no visible reason and medicine didn't help.

We made our appointment with a wonderful eye doctor, but then after hearing what poor Brandon was experiencing, our eye Doctor agreed to see him immediately. We were so grateful. Brandon did not have any horrible incurable disease, he was not dying from a brain tumor, he needed glasses. His eyes couldn't stay focused and so he had trouble seeing things right in front of him. He concentrated extra hard on print in order to read and that is how the headaches began. In short, a year of heartache, headaches, and frustration could have been saved had we only known. He is an A student, and ADD has never been mentioned again. He can now sit still, he loves to read, he enjoys art and his latest achievement is cursive writing. I only wish that somewhere along the way someone had thought to suggest a real vision screening. Brandon thinks he wants to be an eye doctor when he grows up so he can help kids see. Talk about inspiration...Thank you Dr. Cathy.

Don't judge too harshly now, because I am a teacher. I noticed many things, but I believed that because he had the vision screening, both at school and at the Doctor's office, and he did know how to read, it couldn't be his vision. I am so glad that I was wrong and I tell as many people who will listen, "take your child to the eye doctor" you can save them and yourselves from some terrible heartache.

Please continue to support the legislature that will help our children excel. School can be hard enough, but without the proper tools, it can be down right impossible because of something as simple as not having glasses. Help our children be successful, it is our job.

Sincerely,

2/6/2006

Jennifer Canfield

Aug. 18, 2003

To Whom It May Concern:

I am writing this as a concerned parent, hoping it will be heard by our state officials, who establish our rules and guidelines to protect the health and general well-being of our children. We have required pre-school or Kindergarten physicals with state mandated vaccinations to protect our children from contagious and dangerous diseases, but we do not have sufficient vision screening to protect their present and future eyesight. I had never thought about it until I found out first hand.

This past week I discovered by accident that my 3rd grader could not see out of his right eye. We were in the DMV office with my older son who was getting his drivers permit. My younger son (Cody) sat down and peered into the vision machine. The lady officer asked him if he could read the letters, and he read them off. She then said "read the next ones," and he said "what ones." She said the ones after those and she recited the ones he had just read. He responded that there weren't anymore. She gave me a concerned "look" and said he must not be able to see distance in his right eye. I thought a second and then leaned over myself and took a look in the machine and realized he wasn't seeing anything on the right side. My older son and I started pointing out things and asked him to cover his left eye and read them. He squinted and wrinkled his nose and said he couldn't read it. "PANIC" was starting to set in. Can he not see at all out of his right eye? What is wrong with my child's eyes?

Cody looked up at me and said "Mama I told you last year, I couldn't see good out of my right eye." Oh --- yes you did; I waited several days thinking the school would send me a note about an eye exam, but they didn't. So I called the school and recited what he had said, "they checked my eyes and I can't see good out of my right eye". I was told to hold on and a moment later someone came back on the phone and simply said his eyes are fine. That was a whole year ago. A year that my son could have been seeing clearer.

The following morning after the DMV visit I called the eye doctor to find they were booked for weeks. After several phone calls, however, they took pity on a frantic mother and worked him in the next day. It took less than 15 minutes for the eye doctor to find that Cody had Amblyopia, far-sighted in both eyes and the right eye was twice as bad as the left. An appointment was made for the following Wednesday with the pediatric specialist to complete the exam and prescribe his first lenses. His eyes will have to be corrected in stages.

Cody had been diagnosed a little over 2 years ago as being ADHD. He repeated 1st grade. He has been taking a controlled substance for 2 years for ADHD. Now I have learned his vision could have been all or part of his problems in school. Fidgety - inattentiveness, .. I guess so if you're 6 or 7 years old and you can't see well.

The guilt trip I have been on is terrible. I did not recognize any symptoms that Cody couldn't see. You

assume your child is perfect until someone tells you otherwise, and then it is tramatic to a parent to learn there is something wrong with your child. I am sure I am not the only parent to rely on the the school vision screenings. But the school let me down, the pediatrician let me down, he just fell through all the cracks.

During these few days I have talked to school officials at the school he attended last year and the school he is at this year. I inquired about what was in his chart about his eye exam. There was only a date recorded. How did they tell me my son's eyes were fine from just a date. I learned his kindergarten assessment said he had 20/30 vision. His eye doctor finds that hard to believe with the condition his vision is now. This has been a very stressing experience to me, especially because it should have and could have been detected earlier and would not have progressed to the state it is now.

A comprehensive eye exam before he started school would have detected Cody had a vision problem. This should be mandatory state-wide just like the kindergarten physical. A quick look at the eye chart can not detect all the problems they may exist with a childs eyes, like amblyopia. Cody is just a couple of weeks from turning 9 years old, a critical time for just beginning to try to correct this type of vision problem. I thank God Cody was at the DMV with us, for I shudder to think how long this could have gone on undetected. I hope to make other parents aware of the necessity of eye exams for their young children and prevent others from feeling the stress I have felt.

In conclusion, I hope our state will seriously review this proposal and mandate all children to have a comprehensive eye exam. With all the government programs it could be set up low-cost or no-cost at Health Departments for families that might find it difficult financially.

Brenda P. Bennett
92 Emily St.
New Bern, NC 28560
(252) 745-5977
(252) 745-4524

III. Not Alone:
Letters of Support from the Governor of Kentucky, the Kentucky School Board, Kentucky Legislators, and Others

KENTUCKY SCHOOL BOARDS ASSOCIATION KSBA
"A brighter future through better public schools"

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Frankfort, Kentucky 40601
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KSBA Web site: www.ksba.org

March 10, 2006

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Dan Evans
SCHOOL FINANCE AND MANAGEMENT SERVICES
Mark Hampton

The Honorable Ben Chandler
United States House of Representatives
1504 Longworth House Office Building
Washington, DC 20515-1706

Dear Representative Chandler:

Schools can offer the most outstanding educational programs possible, but if children do not come to school healthy and ready to learn then they will miss the opportunities set before them to succeed. Legislation pending before Congress to strengthen children's vision initiatives and to promote new vision screening programs can help ensure that Kentucky's children, and the nation's children, do not fall behind because vision impairments limit their academic progress.

On behalf of the Commonwealth's 176 public school districts, the Kentucky School Boards Association asks that you give children's vision initiatives your support as they come before you. We experience firsthand the importance of vision screening opportunities available to all children in the Commonwealth between the ages of three and six entering preschool, Head Start, or public school for the first time. Early diagnosis and treatment helps many children avoid obstacles to their academic progress caused by vision problems.

Our model of requiring every child entering public school for the first time to have an eye examination by an optometrist or ophthalmologist no later than January 1st of the school year is one that you may want to bring forth for replication in every state. Your support of this and all children's vision initiatives will ensure that far fewer children fall behind and many more children enjoy the academic opportunities that promise them a prosperous future. Should you have any questions about Kentucky's vision screening programs, please contact me at (502)695-4630.

Sincerely,

Bill Scott
Executive Director

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

ERNIE FLETCHER
GOVERNOR

700 CAPITOL AVENUE
SUITE 100
FRANKFORT, KY 40601
(502) 564-2611
FAX: (502) 564-2517

February 21, 2006

The Honorable Ben Chandler
United States House of Representatives
1504 Longworth House Office Building
Washington, DC 20515-1706

COPY

Dear Representative Chandler:

As you and your colleagues prepare to consider legislation during the 109th Congress, I would like to bring to your attention the issue of children's vision. I ask that you give every possible consideration to legislation that would strengthen existing children's vision initiatives and promote new efforts. Our Commonwealth has made great strides in identifying and treating the vision ailments that have for too long limited the ability of many of our children to learn and make academic progress.

In studying early childhood development, Kentucky identified problems with vision as an important factor limiting children's abilities to learn and succeed. In Kentucky, all children between the ages of three and six entering public preschool, Head Start, or public school for the first time must have an eye examination by an optometrist or ophthalmologist no later than January 1st of the school year. In addition, Kentucky has provided much needed help to many children with vision problems and their families at a responsible cost to the taxpayers.

Kentucky's attention to this issue serves as a model for other states that want to ensure that vision problems receive early attention. Most vision problems are easier to correct if identified before age five. Early diagnosis and treatment can help prevent early school failure and the untold costs involved in a child left behind.

I ask you and your colleagues in the Kentucky delegation to carefully consider children's vision initiatives as they come before the 109th Congress. Furthermore, I ask that the federal government consider innovative partnerships with states that are addressing this public health and education concern. Thank you for your consideration. Should you have any questions regarding this issue in Kentucky, please do not hesitate to contact my office at (502) 564-2611.

Sincerely,

Ernie Fletcher

Ernie Fletcher

Kentucky
UNBRIDLED SPIRIT

AN EQUAL OPPORTUNITY EMPLOYER M/F/D

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COMMONWEALTH OF KENTUCKY
HOUSE OF REPRESENTATIVES

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February 21, 2006

COPY

The Honorable Michael F. Easley
Office of the Governor
20301 Mail Service Center
Raleigh NC 47699-0301

Dear Governor Easley:

Six years ago, I had the honor of sponsoring the Early Childhood Development bill. Because of this law, many children have been identified with eye and vision problems who have already been screened at the pediatrician's office. My grandson was one of these. Because of this requirement, my grandson was re-tested and found to have a condition called "lazy eye." It was treated, and he now has perfect vision. Conditions from brain tumors to amblyopia have been diagnosed in children during the comprehensive eye exam required by Kentucky law. These conditions were not suspected by the parent or found in visits to the family doctor. Approximately 13 percent of the children receiving exams before entering school have been identified as needing corrective lenses, 3.4 percent were diagnosed with amblyopia, and 2.3 percent were diagnosed with strabismus.

School administrators have been supportive of this law. They have worked rigorously to ensure that all children comply with the law. Parents have been supportive. Many have been surprised to learn that their child had a vision problem and were very thankful that it was identified and corrected before the child entered school.

The General Assembly originally appropriated $150,000 each year to assist families whose children were not eligible for Medicaid or CHIP or had no private insurance.

Although this program was widely advertised and all schools were made aware of this assistance, not many people applied for the program. Eventually, the budget was reduced to $5,000. The eye care provider community has been generous in assisting schools when there is a need and in helping low-income families obtain the exams. There is adequate access to optometrists and ophthalmologists who are willing to see children for these examinations. In the past six years, I have received no complaints from parents participating in this program.

Your consideration of this law would be good for the state and for the children in your state.

Sincerely,

Tom Burch
State Representative

TB:sl

Commonwealth of Kentucky

STATE SENATE

Robert J. (Bob) Leeper
229 South Friendship Road
Paducah, Kentucky 42003
Office: (270) 554-9637
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Second Senatorial District:
Ballard,
Marshall,
And McCracken
Counties

October 22, 2002

Dr. Joe E. Ellis
109 W. 5th Street
Benton, KY 42025

Dear Dr. Ellis,

I just wanted to drop you a note to update you on my experiences with the entrance level eye exam provision of the early childhood package. As you know I was somewhat hesitant of this mandate and anticipated a possible outcry from parents over this additional requirement.

I am happy to report that after several cycles I have yet to receive the first complaint. You and you colleagues are to be commended on your efforts to address this issue and for implementing this program in a patient friendly manner.

Sincerely,

Robert J. "Bob" Leeper
State Senator

RJL/ajr

Save New Eye Exam Law

I just learned the new mandatory eye exam law for all children entering kindergarten in North Carolina has been put on hold due to a lawsuit deeming the legislation "unconstitutional" and strong opposition from school boards, pediatricians, ophthalmologists, and Prevent Blindness America.

As the mother of a child who experienced the inadequacy and ineffectiveness of vision screenings, I am shocked that individuals and professional organizations would challenge the benefits and efficacy of eye exams. How could anyone oppose something that is good for the children before they begin one of the most important grades—kindergarten?

According to the latest study funded by the National Eye Institute, vision screenings missed between 32% and 63% of vision problems diagnosed by eye examinations. Since academic learning is mainly visual, comprehensive eye and vision examinations by an eye doctor are important for all children first entering school and regularly throughout their school-aged years. Undiagnosed and untreated vision impairments can seriously interfere with learning and contributes to poor performance in school.

I strongly advise all pediatricians, school officials, technicians, and anyone administering vision screenings to properly inform all parents before a vision screening is conducted with a disclaimer that states, "Vision screening is *not a substitute* for a complete eye and vision evaluation by an eye doctor." I also highly recommend that all eye doctors utilize a report form following a child's eye appointment. This will increase communication between the doctor and parent as well as encourage compliance with the doctor's treatment recommendations. Parents and teachers need to be aware of each child's visual abilities and specific eye care needs so that the best educational program can be provided.

I urge all optometrists, ophthalmologists, pediatricians, school boards, and legislators to put aside their differences and instead, join forces by learning all you can about children's vision and the value of comprehensive eye and vision examinations. Let's focus on what's really *best* for our children. This simple advice could save a child's vision and ensure success in school.

Mrs. Janet V. Hughes, Founder and Director
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IV. On Solid Ground: Relevant Studies and Reports Favor Children's Eye Examinations

Report on Kentucky Experience with Preschool Eye Examination Laws

Since the Kentucky General Assembly passed House Bill 706 in 2000, which included a provision that all children entering Kentucky public schools should have an eye examination by an optometrist or ophthalmologist, we have received numerous inquiries. This document will answer some of the frequently asked questions.

Q. In the five legislative sessions since this law was implemented, has there been any attempt to change it?

A. A technical amendment was made in the 2002 session that clarified that the law applied to 3-6 year olds. Some school systems thought it might apply to high school students transferring in from other states. During the 2001, 2002, 2003, 2004 and 2005 sessions, there was NO suggestion from any legislator or testifier that the basic tenet of the law – a comprehensive exam by an optometrist or ophthalmologist – be modified in any way.

In the 2005 session, as part of a bill called Read to Achieve, the General Assembly actually expanded the eye exam law by mandating that primary students, regardless of age, who are having difficulty reading may be referred and receive a second vision examination by an optometrist or ophthalmologist at no cost to the parent. This bill passed with no dissenting votes in either House or Senate.

If people were upset over the law, legislators would be hearing about it and taking action to change it. They certainly would not be willing to require further eye exams for students.

Q. What has the reaction of school officials and teachers been to the law?

A. We have seen an overwhelmingly positive reaction. Schools have been diligent in enforcing the provision. We have numerous letters from school personnel praising the results they are seeing from the law. For example, the Jefferson County (Louisville) School Superintendent, the largest school system in the state, wrote to the Chair of the Senate Education Committee that they would be opposed to any changes in the requirement. Private and parochial schools have voluntarily implemented a preschool eye exam for their students after hearing about the success of the effort.

Q. What has the reaction of parents been?

A. Again, very positive. Many parents were very surprised to learn that their child had a vision problem and praise the requirement. We have many letters from parents in support of the provision. Also, once the parents learn what a true eye examination is, they realize that their older children need to be checked and voluntarily schedule appointments for eye exams for them.

Q. What has the reaction of state officials been?

In testimony before a legislative committee on the outcomes of the Early Childhood Law which included the eye exam requirement, the pediatrician who is the director of the Division of Adult and Child Health for the Department of Public Health testified that the law was working wonderfully and had resulted in many children having early diagnosis of eye and vision problems. On another occasion, the director of the Commission for Children with Special Health Care Needs told a legislative budget committee how well the law worked and how many children had benefited because of it.

Q. Have there been adequate numbers of optometrists and ophthalmologists to see the children?

A. Yes. The law gives a grace period until January 1 after the child enters school to get the official eye exam form in to the school. Many parents now schedule examinations in the spring before the child enters school in August.

Q. Have families been burdened in paying for the eye examinations?

A. Evidently not. There are numerous resources in Kentucky to assist families in paying for the exam. Medicaid and KCHIP cover children whose family's incomes are up to 200% of poverty. The state allocated $150,000 per year to pay for exams for children not eligible for other programs and who did not have private insurance coverage. In spite of a great deal of publicity and the schools pushing the program, only 75 exams were paid for in 2000 and 66 in 2001. Due to the underutilization of this program, the 2002 General Assembly reduced the allocation to $50,000. There are also numerous private resources that help cover examinations, including Sight for Students and the Lions Clubs. The Kentucky Vision Project, an 18 year old charity started by Kentucky optometrists, pledged that any child whose families did not qualify for other resources to pay for the exam and glasses if needed, would be seen free of charge.

Q. What are the findings on these children who have the exams?

A. Surveys of doctors based on information provided on the official exam report form, reveal that many of these children have previously undiagnosed eye and vision disorders. From over 5000 exams performed, approximately 13% needed glasses. Numerous other eye problems and even a brain tumor were diagnosed as a result of the new law.

Q. Do the results justify the costs?

A. Yes. Compared to two other nationally required health tests on children the incident of problems is much higher. Even taking a conservative estimate of 10% of preschoolers having eye/vision problems, compared to testing for PKU which is done on newborns in hospitals and infant hearing testing required in 33 states, the results are as follows.

EYE/VISION ratio	100:1000
PKU ratio	.0001:1000
Hearing ratio	.003:1000

Q. Does this law eliminate the need to do school vision screenings?

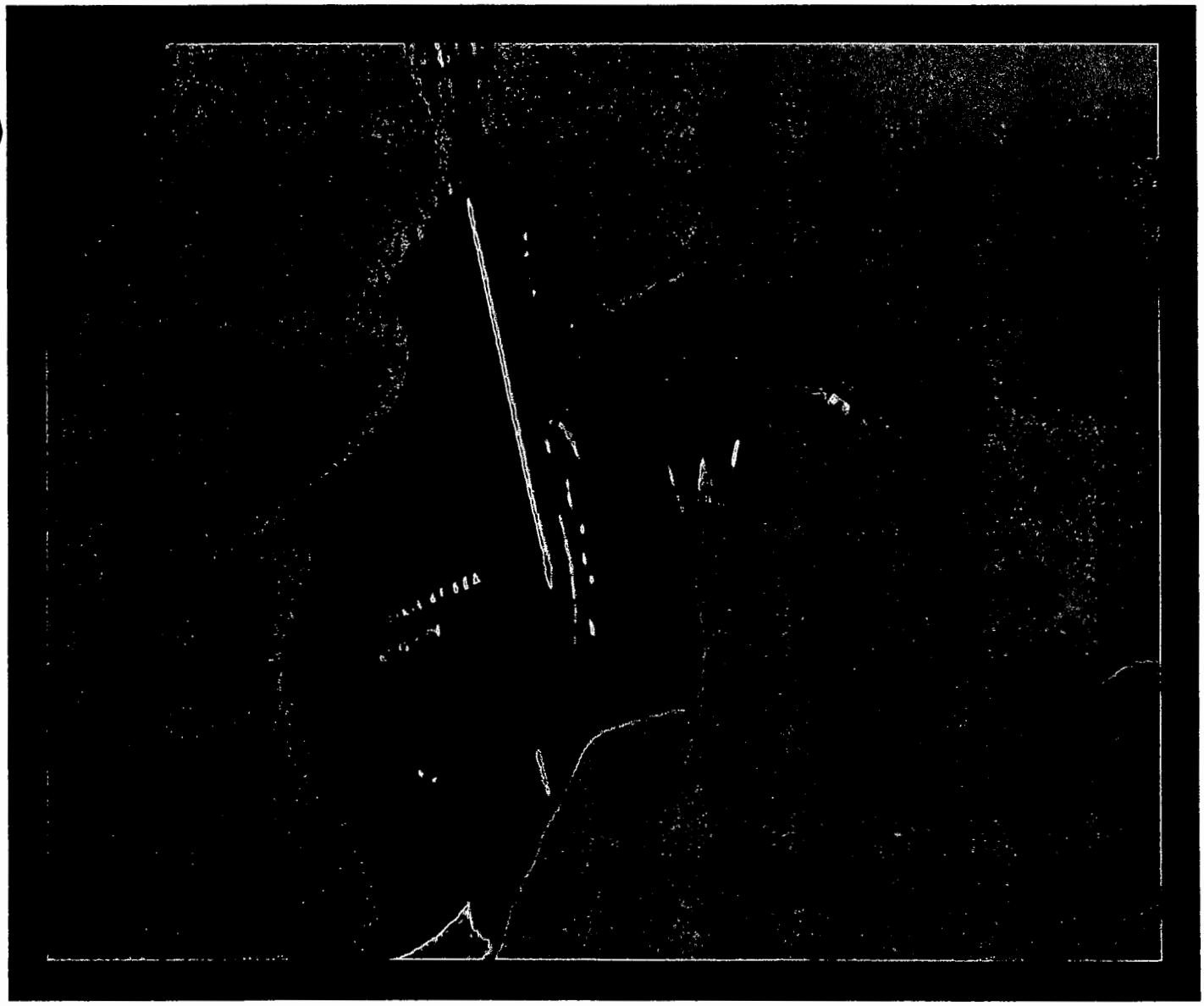
A. No. This law insures that when a child enters school that they have had their eyes examined for vision and eye health problems. This way they will begin their education with optimum eyesight. It also results in early invention for problems like amblyopia that must be treated at a young age before the damage is irreversible. As children grow their eyes are subject to change, and will still need to be checked periodically.

Q. Has there been any follow-up assessment by the state on the eye examination law?

A. Yes. The Kentucky Department of Education established a task force in 2004 to evaluate the outcomes of the 2000 Kentucky Early Childhood initiative, "KIDS NOW" and make recommendations for changes. The Kentucky eye exam requirement was part of that law. In the final report of the task force, the only recommendation regarding the eye exam law was to enhance parent-teacher communication to include more information on the value of the eye examination.

Darlene W. Eakin
Executive Director
Kentucky Optometric Association

3/9/05



Eye Exams for Children: Their Impact and Cost Effectiveness

Executive Summary

Prepared by Abt Associates for the Vision Council of America

Acknowledgements

We are grateful for the contributions made by the expert panel that advised us on the study. This panel included Alex Kemper M.D., M.P.H., M.S; William Reynolds O.D.; James Tielsch Ph.D., M.H.S.; and Joel Zaba, M.A., O.D.

The panel provided general guidance on the structure of the model, suggestions about relevant articles to include in our literature review, gave input as to the values of model inputs, and reviewed the Final Report.

We also wish to thank Paulette Schmidt O.D., M.S. and Susan Taub M.D., F.A.C.S. for the articles that they furnished to us.

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Executive Summary

Comprehensive eye exams and vision screenings are two methods used to detect amblyopia and other visual disorders in children. Eye exams are performed by an ophthalmologist or optometrist and are used to diagnose vision problems. Vision screenings are conducted by non-medical volunteers, nurses and pediatricians and used to identify people at risk for vision problems.

The goal of the study was to estimate the impact and cost effectiveness of providing comprehensive eye exams to all preschool-age children. We compared the universal provision of eye exams to two interventions: (1) a system in which all preschool-age children receive a vision screening and (2) the eye care that would be provided to children even without the presence of a formal vision screening or eye exam program.

Results

(1) Eye exams would detect, treat and cure significantly more cases of amblyopia in children than a universal vision screening program or the "usual patterns of care" that would exist without a formal vision screening program in place.

It is estimated that nearly 100,000 four-year-olds in America have amblyopia. Even without a formal vision screening system in place, many of these children would have their vision problems identified and treated as part of the usual health care they receive.

However, replacing a system that relies on "usual care" with one that provides universal eye exams would result in 51 percent more children receiving successful treatment for amblyopia by age 10. The following table compares the effectiveness of universal eye exams to "usual care":

Percent of amblyopia cases...	Universal Eye Exams	Usual Care	Percent Gain
Receiving treatment by age 10	98%	77%	27%
Receiving successful treatment by age 10	68%	45%	51%

Universal eye exams would also outperform a program of universal vision screenings and successfully treat 33,000 (144 percent) more children with amblyopia. The table below compares the effectiveness of universal eye exam and universal vision screening programs:

Cases of amblyopia...	Universal Eye Exams	Universal Screenings	Difference	Percent Gain
Detected in initial visit	94,171	64,433	29,738	46%
Receiving treatment	75,337	30,928	44,409	143%
Successfully treated/cured	56,503	23,196	33,307	144%

(2) A universal comprehensive eye exam program would be highly cost effective and produce a greater return on investment than many other health care interventions.

Our measure of cost effectiveness is based on a comparison of the costs of these interventions against the improvement in outcomes (quality/length of life) they generate. Cost effectiveness is measured in QALYs (quality-adjusted life-years), a unit that expresses the additional costs required to generate one year of perfect health (1 QALY).

There are no universally accepted standards, but if an intervention costs less than $50,000 per QALY it is generally considered cost effective; if it costs less than $20,000 per QALY, it is generally considered highly cost effective. Assigning a QALY value to different interventions allows policymakers and providers to prioritize and focus on interventions that give the greatest return at the lowest cost.

Replacing a system of "usual care" with universal preschool-age eye exams was highly cost effective at a cost of $12,985 per QALY. Universal eye exams were also highly cost effective when compared to universal vision screenings at cost of $18,390 per QALY. The table at right provides QALY values of other common medical interventions (ophthalmic interventions in **bold**.)

QALY values for selected medical procedures

Intervention	Cost/QALY*
Liver transplantation	$350,000
Central retinal artery occlusion (paracentesis)	**$345,000**
Annual retinopathy screening for 45-y.o. diabetes patient	**$231,000**
Photodynamic AMD therapy (20/200 vision)	**$174,000**
Elective repeat cesarean birth	$120,000
Lung transplantation	$120,000
Photodynamic AMD therapy (20/40 vision)	**$87,000**
PVR eye surgery	**$80,000**
Dual-side air bags	$76,000
Diabetes screening (all individuals 25+ y.o.)	$67,000
ESRD treatment, including dialysis and transplants	$67,000
Hepatitis A vaccination (vs. no vaccination)	$54,000
Heart transplantation (vs. optimal treatment).	$51,000
Annual retinopathy screening for 45-y.o. diabetes patient	**$44,000**
Chemotherapy (for 60 y.o. woman with breast cancer)	$41,000
One-time screening for depression (for 40 y.o.)	$35,000
Driver-side air bags	$30,000
Typical school-based tobacco prevention program.	$22,000
Breast cancer screening vs. no screening for 70-75 y.o. women	$21,000
Cochlear implant for deaf individual	$20,000
Hypertension screening (for asymptomatic 60 y.o. woman)	$19,000
Universal eye exams for children vs. universal screening	**$18,390**
Universal eye exams for children vs. "usual care"	**$12,985**
Bone marrow transplantation	$11,000
Universal cancer screening program (vs. no screening)	$5,200
Cataract surgery	**$4,500**

*In 2002 dollars. The source for many values is the Harvard Center for Risk Analyses, Harvard School of Public Health, Comprehensive Table of Cost Utility Ratios, 1976-2001, ww.hsph.harvard.edu/cearegistry

Background

Amblyopia affects up to five percent of the population and is the leading cause of unilateral vision loss among those aged 20 to 70. The consequences of untreated amblyopia may include blindness, problems with school performance and effects on quality of life. A number of previous studies have found that early detection of amblyopia provides the best opportunity for effective treatment.

Comprehensive eye exams are considered by all eye care professionals to be the "gold standard" for detecting amblyopia and other vision problems in children. Several studies also suggest that eye exams are more effective than vision screenings in terms of ensuring appropriate treatment for amblyopia. However, they are more costly to perform than vision screenings.

A recent study suggests that vision screening, even when performed by pediatric eye specialists, identifies only about three-fourths of children with amblyopia.

It is almost certain that vision screening tests given by non-eye care professionals are less effective. In addition, several studies suggest that many children who fail a vision screening do not receive the appropriate follow-up evaluation and care.

As a result of the performance differences between exams and screenings, some children who receive comprehensive eye exams are likely to have amblyopia identified and treated earlier than if they had received a vision screening.

Methodology

Our goal was to determine if the benefits resulting from exams' higher rates of detection and treatment offset their higher costs. By understanding the costs and likely benefits, one can better evaluate the level of resources society should devote towards promoting eye exams for all preschool children.

We assessed the cost effectiveness by using cost-utility analysis. This is a method of economic evaluation that analyzes the cost effectiveness of interventions by comparing the benefits of a medical intervention (in this case, eye exams) to the costs of providing that intervention (in this case, both examination and treatment expenses).

Our cost-utility analysis is measured in QALYs (quality-adjusted life-year), a unit that expresses the additional costs required to generate a year of perfect health. A QALY takes into account both quantity and the quality of life generated by intervention being studied and provides a common unit of measurement by which a wide range of medical interventions can be compared.

Because comparisons of cost-effectiveness can be made among interventions, cost-utility analysis means that priorities can be established based on those interventions that are inexpensive (low cost per QALY) and those that are expensive (high cost per QALY). An intervention is generally considered cost effective if it costs less than $50,000 per QALY and generally considered highly cost effective if costs less than $20,000 per QALY.

The economic model we developed to compare these interventions focuses on amblyopia. This is the only vision disorder typically identified during comprehensive exams/vision screenings for which there was sufficient information in the medical literature. Given an initial prevalence of amblyopia in the study population, the model takes into account the following:

(1) The relative performance of comprehensive exams and vision screenings;
(2) The probability that treatment is successful;
(3) The costs of exams, screenings, and treatment;
(4) The utility values associated with healthy vision, amblyopia, and amblyopia-caused bilateral impairment;
(5) Patterns of treatment under usual eye care.

To estimate model parameters, we conducted an extensive literature review and also consulted with the panel of experts who advised us on the study. While there is an extensive literature on amblyopia and other visual disorders, there are significant gaps that affect our ability to precisely measure

several key model parameters and differences across relevant studies in their estimates of model parameters.

For example, little data has been published on the relative performance of comprehensive exams and vision screenings, the costs and outcomes associated with treating amblyopia, or the impact of untreated amblyopia on quality of life. We developed a set of base values that represent our best estimates, but these are subject to uncertainty given the range of values found in the literature.

Sensitivity analyses were used to examine how results change using different values of model parameters. We found that changes in the values of most model parameters had marginal impact on the basic conclusions of the report. However, results were particularly sensitive to assumptions made about the quality of life associated with untreated amblyopia, prevalence, and the probability of successful treatment.

Conclusion

The study's conclusions are largely driven by the fact that treatment of amblyopia is extremely cost effective. While data are limited, we estimate that treating amblyopia (not including detection) costs about $1,800 per QALY. As a result, spending additional dollars on interventions that detect and treat large numbers of children with amblyopia are also highly cost effective.

That a vision screening costs less to perform than an eye exam is not the only relevant factor in assessing cost effectiveness. What is relevant is a comparison of the costs and the benefits associated with each procedure. Based on our evaluation, the higher costs associated with eye exams are more than offset by the gains that result from the additional children who are successfully treated as a result of receiving an eye exam.

In conclusion, it was beyond the scope of this study to address issues related to the feasibility of requiring comprehensive eye exams for preschool children. However, the study suggests that policymakers should give consideration to programs that would increase the number and proportion of preschool children who receive a comprehensive eye exam from an eye care professional.

These gaps in our knowledge illustrate the clear need for further research on amblyopia and other visual disorders in order to refine estimates of model parameters, allowing for more precise estimates of the costs and benefits of comprehensive exams.

INDIVIDUAL SUPPORTIVE EDUCATION REFORM AGENDA FOR NEW JERSEY READING

This is the first in a series of reports by the Commission on Business Efficiency of the Public Schools on the topic of Special Education Reform. This report focuses on the impact of the quality of reading education on special education classifications.

SUMMARY

This study included extensive meetings with members of the special education community in New Jersey, individuals involved in this issue in other states, national education research organizations, the examination of legislative activity on this topic in all of the other forty-nine states as well as extensive research of available literature.

One inescapable conclusion of this examination is that children with reading difficulties who do not receive intervention services are much more likely to be classified as requiring special education than those students with reading difficulties who receive such services. The Commission found that if early intervention reading programs with universal screening and follow-up had been available to all of New Jersey's public school children, the State would realize annual cost avoidance in special education funding of $200 Million.

During the course of the examination, the question of the impact that vision care has on reading and thereby on special education classifications was also raised. Studies have indicated that a significant portion of children classified as needing special education had undiagnosed and untreated vision problems, which may affect reading ability. This occurs even though all school age children receive vision screenings as required by law.

As a result the Commission recommends that reading screenings be administered to all first and second grade pupils at the end of the academic year and that remedial reading programs be implemented to correct reading deficiencies. The Commission also recommends that students receive full vision examinations prior to entry to school

PROBLEM

The focus of the 1997 amendments to the federal Individuals with Disabilities Education Act (IDEA) to ensure the success of students with disabilities and improve their academic achievement is very similar to the goals for which we in New Jersey have struggled. It is important that we accomplish these goals within the effort to provide all students with the highest quality of education possible. This is important both as a matter of law and because of the strongly held value we in New Jersey place on a quality education for all our children.

It is important to point out that special education programs in New Jersey have accomplished much for students who otherwise would be underserved or not served at all. New Jersey has a long history of progressive thinking and action in the field of

special education. The school personnel charged with identifying and providing services to students have a right to take pride in their efforts to provide the best possible education to children requiring special services. Our laws, both as enacted by the Legislature and interpreted by our courts, have always been overzealous in guaranteeing that children needing services receive them. This tradition has produced a culture in New Jersey education that, as a whole, seeks to promote rather than deny special education services.

While this culture is a strength, it has also created rigidity in structure that, at times, prevents flexibility in its operation. One aspect of this problem is the view held by many in the system (teachers, administrators and advocates) as well as clients of the system (students and parents) that the options for assisting a child encountering a reading difficulty are limited. The culture, our funding structure and the range of options available to provide services all contribute to this difficulty.

In the view of the Commission children with reading problems who could avoid later classification through early intervention fall into two groups: (1) children who have problems mastering basic reading skills and (2) children with undiagnosed and/or untreated visual problems which prevent them from acquiring reading skills.

Reading Skills and Special Education Classification. The impact of this changing special education culture on reading seems to have been a decline, over time, of the availability of quality early intervention for students with reading difficulties. Children with reading difficulties have long comprised the single largest portion of students classified as specific learning disabled (SLD). Nationwide some 80 percent of SLD students have primary difficulties with reading. Research indicates that as many as 70 percent of these students would not have been classified had they been appropriately screened prior to first grade and thus received early intervention strategies.[1] Unfortunately under present practice many of these children struggle in traditional classroom programs until they are classified as SLD at the end of second or the beginning of third grade.

Vision and Reading Skills. According to James Kimple[2]:
"Since school tasks rely primarily upon the eyes for acquiring information, it seems logical to make every effort to help (the perceptually impaired) develop their visual skills... If the child study team refers (the student) for visual examination, the child usually goes to the family physician who just as often returns a report stating that the child has 20/20 vision. The child receives no further help until finally classified... Most of us assume that all children with normal acuity are able to see well enough to do nearpoint work. Nothing could be further from the truth."

He points out that remediation is not likely to improve such a student's academic performance. In this case remediation treats a symptom and not the root problem. It is the visual problem that must be addressed. Considerable research has linked visual skill and reading performance. Many of the correlations are between reading and conditions such as anisopmetropia, binocular coordination, focusing skills, ocular motor efficiency and fixation disparity[3]

Recent studies looking at learning related visual problems in both "regular" and special needs students has produced interesting results. Studies in Boston[4], and Baltimore[5] have found that as high as 85 percent of tested children failed at least one screening for a visual problem that could lead to learning difficulty. The highest numbers appear to occur among special education students. Other studies echo these results and show a high occurrence of undiagnosed or untreated visual problems among special education students as well as among the adult illiterate.

In July of 2000 Governor Paul Patton of Kentucky signed into law House Bill No. 706 which requires all to have "a vision examination by an optometrist or opthalmolgist" before entering the public school system. A follow-up study of this legislation was published in the Journal of Behavioral Optometry in 2003[6]. The study examined results on 2, 916 children who received vision exams in 2002 including information regarding their history of vision screening during the prior year. This study found that approximately 10.4 of the children had vision problems which went undetected during simple vision screenings but were detected in the more comprehensive vision examination. The study also found that the occurrence of vision disorders in Kentucky matched normal prevalence rates for the children in the general population. Assuming that New Jersey's children also experience disorders in line with the norm, then estimating that 10.4 percent of children entering the public school system also have undiagnosed vision disorders is reasonable. There are roughly 310,000 children enrolled in grades pre-K through third grade (the point at which the second vision screening is due under current law.) Assuming the 10.4 percent estimate above, currently there are 32,000 New Jersey public school students with undiagnosed vision problems, who may not be detected before they reach age 9, attempting to learn to read. After age nine improvements in reading skills becomes extremely less likely for students with reading difficulty. The Commission believes that these children experience a higher likelihood of special education classification than other children.

CURRENT STATUS

Reading Programs. Over the past two years the State has engaged in a more aggressive approach to early literacy. The State has launched the Reading First Program, which has a long range goal of implementing screening and intervention in the early grades in all of New Jersey's public schools. The program includes $10 million per year for four years to fund reading mentors. As of the time of this report Reading First is running in 22 school districts. The New Jersey Department of Education is also making progress in reading programs in the Abbott districts. However, this leaves over 500 school districts without a state supported early intervention reading program.

Vision Programs. Currently the State requires a vision screening of all students as part of required student medical examinations (N.J.A.C. 6A:16-2.2.) This examine is required three times during the child's K-12 schooling: once by the end of third grade, once by the end of sixth grade and once more prior to the end of twelfth grade. The first test focuses on visual acuity but does not test for conditions such as anisopmetropia, binocular coordination, focusing skills, ocular motor efficiency or fixation disparity

IMPACT OF FAILING TO PROVIDE INTERVENTION ON STATE AID

In New Jersey approximately half of all students with a special education classification are classified as Specific Learning Disabled. That is a little over 100,000 children[7]. Applying the national estimates would indicate 70,000 children with reading difficulties or 56,000 children now classified as requiring special education services who might not be had they received early intervention reading services. This does not include students who could benefit from early intervention reading assistance. There are approximately 200,000 special education students in the State. State aid for special education for the 2003-2004 school year is over $900 million or $4,500 dollars per classified student. (While many affected students will generate other special education funding this analysis uses the tier two amount of $3,329 for calculating savings in table one). Not including local costs, if we had provided these children with appropriate early intervention reading assistance, the savings would be two fold: 1) $200 million dollars per year in special education aid costs, and 2) the rescued lives of thousands of children each year. Per grade level, the savings would be approximately $20 million. Applying this savings estimate to grade levels K-2 would generate $50 million buy the end of the sixth year. Annual savings would then increase each year as these children avoid classification until it reached approximately $200 million per year. The total cost per year for such a program in a state with a similar size population to New Jersey (Virginia) is $22 million including local share. An initial program costing $22 Million could yield cumulative savings of more than one half $Billon within ten years. While New Jersey has a larger at-risk population, the probable cost of an early intervention program is well under the annual savings.

Table 1. Low end estimate based on tier two funding and no residual savings and no federal funding.

Program year	Annual cost ($Millions)	Annual Savings ($Millions)	Net ($Millions)	Cumulative ($Millions)
Year One	$22	$0	($22)	($22)
Year Two	$22	$36	$14	($8)
Year Three	$22	$39	$17	$9
Year Four	$22	$58	$36	$45
Year Five	$22	$80	$58	$103
Year Six	$22	$103	$81	$184
Year Ten	$22	$197	$175	$744
Year Fifteen	$22	$232	$210	$1,773

*Table 2. High end estimate based on average aid to capture residual saving and federal funding to cover the cost of the program. (in 2001 Dollars)

Program year	Annual cost ($Millions)	Annual Savings ($Millions)	Net ($Millions)	Cumulative ($Millions)
Year One	$0	$0	$0	$0
Year Two	$0	$50	$50	$50
Year Three	$0	$53	$53	$103
Year Four	$0	$80	$80	$183
Year Five	$0	$110	$110	$293
Year Six	$0	$142	$142	$435
Year Ten	$0	$272	$272	$1,331
Year Fifteen	$0	$320	$320	$2,903

*The above tables are in 2001 Dollars. Calculations assume a 4 percent growth in SLD placements based on the average change in SDL from 1990-2000 adjusted for tracking changes as well as an aggressive reading campaign in grades1-3..

Findings

- Approximately half of all New Jersey students with a special education classification are classified as Specific Learning Disabled (SLD).

- The rate of growth in SLD classified children in recent years has been 9 percent while total school enrollment has grown at only 2 percent based on available data.

- Nationwide some 80 percent of SLD students have primary difficulties with reading. As many as 70 percent of these students might not have been classified had they received appropriate early intervention.

- Undiagnosed and untreated vision related learning problems are significant contributors to early reading difficulties and ultimately to special education classification.

- Vision in very young children can change significantly in a one year period.
- The current requirement for vision screening of public school children for acuity only is inadequate.
- The number of students being classified as requiring special education continues to increase.
- Limited alternate intervention options are open to teachers, students and parents to assist a child not thriving under the current approach result in unnecessary classification in special education.

❑ Over the past two decades programs implemented by reading specialists with young students who demonstrate a difficulty in learning to read have been replaced by full entry into the special education classification system.

❑ Few students return to full-time general education once classified in special education.

❑ Current pre-service preparation does not equip teachers to assess reading deficiencies and provide adequate intervention.

❑ Current staff development does not provide the skills teachers need to assess reading deficiencies and provide adequate intervention.

❑ The current funding structure does not support intervention remedies to assist reading deficient students short of special education classification.

❑ The current funding structure draws focus to a limited number of high-cost student placements drawing funds away from early intervention.

Goals for Reform

❑ Eliminate unnecessary referrals to special education

❑ Guarantee that any student who can benefit is provided with appropriate support and assistive or remedial services.

Vision

The Commission on Business Efficiency of the Public Schools has adopted a vision for education of children who encounter learning difficulties:

All of New Jersey's public school students will receive the programmatic support necessary to enable them to achieve at their highest level.

Recommendations

❑ The State should provide seed money for the implementation of reading screenings and appropriate research-based, early intervention reading programs for pre-Kindergarten through second grade in two pilot districts in each county.

❑ Require New Jersey school districts to adopt reliable, replicable research based reading programs, one of which must be a systemic phonics based program to be eligible to receive reading program aid.

❑ Provide reading readiness academies for teachers Pre K-3.

❑ Refocus pre-service and in-service programs to improve educator's skills in identifying and assisting students with reading difficulties.

❑Provide for literacy screening during the Kindergarten year to identify students with reading difficulties.

❑The Legislature should require that children present a vision examination certificate signed by an ophthalmologist, optometrist or qualified physician prior to entry into a public school. The report must include the results of a vision examination performed within six months prior the time that a three (3), four (4), five (5), or six (6) year old child is enrolled in a public school, public preschool, or Head Start program. The examination must include measurement of visual acuity in each eye at various distances; assessment of ocular motility and alignment, including eye tracking; strabismus and measurement of actual refractive error; binocular fusion abnormalities; and evaluation of general ocular health, including external assessment.

[1]Lyon, Fletcher, et al., "*Rethinking Learning Disabilities*", 2001
[2] Kimple, James, "*Eye Q and the Efficient Learner*", 1997
[3] Kulp, M.T, Schmidt, P.P., *"Visual Predictors of Reading Performance in Kindergarten and First Grade Children"*, 1996
[4] Orfield, Antonia, OD, MA, FCOVD, *"Vision Problems of Children in Poverty in an Urban School Clinic: Their Epidemic Numbers, Impact on Learning, and Approaches to Remediation"*, 2001

[5] Harris, Paul, OD, "*Learning-Related Visual Problems in Baltimore City: A Long-Term Program*", 2002
[6] Zaba, J.N., Mozlin, R, Reynolds, W.T., Insights on the Efficacy of Vision Examinations & Vision Screening For Children First Entering School", Journal of Behavioral Optometry, vol 14/2003/no. 5

[7] New Jersey Department of Education, *State Special Education Data for 2000-2001*

NEW CDC STUDY: MANY U.S. CHILDREN NOT RECEIVING PROPER VISION CARE.

According to a recent report from the Centers for Disease Control and Prevention (CDC), only about one in three children in America have received eyecare services before their sixth birthday. The "Visual Impairment and Use of Eye-Care Services and Protective Eyewear Among Children" findings, published in the *Morbidity and Mortality Weekly Report*, were the result of a national survey of more than 12,000 participants. The study also found that compared to black or white children, Asian and Hispanic children in the United States were less likely to get their vision checked. Hispanic children have a higher prevalence of visual impairment and blindness than white children (3.6 percent vs. 2.3 percent), according to the study. The CDC report also examined the issue of eye safety in sports. Only 14.6 percent of all children aged six to 17 consistently wear protective eye gear during sports activities, the study shows--and girls are less likely than boys to wear protection. Of the nearly 36,000 sports-related eye injuries treated in U.S. hospital emergency rooms in 2002, more than 40 percent were to children age 14 and younger, and many were avoidable. The CDC study is available at ***www.cdc.gov/mmwr/preview/mmwrhtml/mm5417a2.htm***

NEI Statement

Vision in Preschoolers Study, Phase I

National Eye Institute
National Institutes of Health

Results from the first phase of the Vision in Preschoolers (VIP) study were published in the April 2004 issue of the journal *Ophthalmology.* VIP is a three phase study designed to evaluate the effectiveness of vision screening tests commonly used for preschool-aged children. The study was funded by the National Eye Institute, a part of the National Institutes of Health, Department of Health and Human Services.

Many different vision screening tests are used widely. However, none have been compared to each other and to comprehensive eye examinations to determine how accurate the tests are in detecting children with symptoms of common vision disorders. Children with symptoms require a comprehensive eye examination to diagnose and treat their condition.

In Phase I of the VIP study, children were first screened by a licensed eye care professional who was experienced in working with children and who had been trained and certified to administer these vision screening tests. The children were then given a comprehensive eye examination using standardized diagnostic procedures and tests--referred to professionally as a "Gold Standard Eye Examination"--by an optometrist or ophthalmologist who did not know the results of the child's prior screening test. In this way, the study researchers could compare the results from screening tests and comprehensive eye examinations to evaluate the accuracy of the screening tests.

Phases II and III of the VIP study will evaluate screening tools when administered by pediatric nurses and trained lay screeners, providing insight into the effectiveness of vision screening tests in real world settings. Phase II of the VIP study is now underway. The NEI will release new study results when they become available.

April 1, 2004

The National Eye Institute (NEI) conducts and supports research that leads to sight-saving treatments and plays a key role in reducing visual impairment and blindness. The NEI is part of the National Institutes of Health (NIH), an agency of the U.S. Department of Health and Human Services

Vision In Preschoolers Study (VIP Study)

Purpose | Background | Description | Patient Eligibility | Recruitment Status | Current Status | Results | Publications | Clinical Centers | Resource Centers | NEI Representative

Purpose

To identify whether vision-screening tests can accurately identify preschool-aged children who would benefit from a comprehensive vision examination because of signs of amblyopia, strabismus, significant refractive error, and associated risk factors.

Background

Vision disorders are the fourth most prevalent class of disability in the United States and the most prevalent handicapping conditions in childhood. Early detection increases the likelihood of effective treatment and allows for actions to decrease the negative impact of the disorders. However, fewer than 15 percent of all preschool children receive an eye examination. Fewer than 22 percent of preschool children receive some type of vision screening. The methods for vision screening vary tremendously and the effectiveness of the methods in appropriately identifying children has not been documented. Amblyopia (2-5%), strabismus (3-4%), and significant refractive error (15-20%) are the prevalent and significant vision disorders of preschool children.

Description

The Vision In Preschoolers (VIP) Study is a multi-phased, multi-center, interdisciplinary, clinical study to evaluate the accuracy of screening tests used to identify preschool-aged children in need of further evaluation for vision disorders. The primary goal of the VIP Study is to determine whether there are tests or combinations of tests that can be used effectively to determine which preschoolers would benefit from a comprehensive eye examination to detect amblyopia, strabismus, significant refractive errors, and associated risk factors. The VIP Study is designed in phases.

- **Phase I (Years 1 and 2)** was conducted over a two-year period. Phase I activities established which screening tests performed well when administered by licensed eye care professionals (optometrists and ophthalmologists experienced in the care of children) in a population of at least 2,000 Head Start preschoolers (at least 1,000 children per year) at

high risk for the targeted vision disorders. Year 2 activities included evaluation of the performance of some commercially-available technology-based screening tests when administered by licensed eye care professionals. Year 2 activities also included evaluation of whether a selected set of tests was amenable to administration by lay screeners.

- **Phase II** activities will establish which screening tests perform well when administered by pediatric nurses and lay people on a high-risk population of at least 1,000 Head Start preschoolers. Each child will be tested twice with each screening test - once by a pediatric nurse and once by a lay screener. Tests selected for Phase II were determined by the outcome of Phase I.
- **Phase III** activities are currently under development. The category of screening personnel and the specific screening tests used in Phase III will be determined by the outcome of Phases I and II.

Description of Phase I

Phase I of the VIP Study provided estimates of the sensitivity and specificity of each of 11 screening tests and selected combinations of tests for detecting one or more of three targeted conditions (amblyopia, strabismus, and significant refractive error) and associated risk factors when the tests were conducted by licensed eye care professionals. Further, information on the most appropriate age-specific pass/fail criteria for tests was obtained during this phase.

In addition to completing the screening procedures, each child underwent a comprehensive eye examination by a licensed eye care professional who was masked to the results of the screening. Data collected during this eye examination was used as the gold standard with respect to the absence or presence of the conditions targeted for detection.

The 11 screening tests used in Phase I of the VIP Study were:

- Lea Symbols Visual Acuity Test (Precision Vision)
- HOTV Symbols Visual Acuity Test (Precision Vision)
- Random Dot E Stereoacuity Test (Stereo Optical)
- Stereo Smile Test II (Stereo Optical)
- Cover-Uncover Test
- Noncycloplegic Retinoscopy
- Retinomax 2 Autorefractor (Nikon)
- iScreen (Digital Vision Screening Technology)
- MTI Photoscreener (Medical Technologies Inc.)
- PowerRefractor II (plusoptiX)
- SureSight Vision Screener (Welch Allyn)

Additional tests administered by lay screeners in Year 2 were:

- Lea Symbols Visual Acuity Test (Precision Vision)
- Stereo Smile Test II (Stereo Optical)

Description of Phase II

In Phase II of the VIP Study, tests in need of further evaluation are being used by pediatric nurses and lay screeners to determine if the tests are amenable to administration by personnel with less training than licensed eye care professionals. Screenings are taking place in realistic screening environments.

The 4 screening tests being used in Phase II of the VIP Study are:

- Lea Symbols Visual Acuity Test (Good-Lite Company)
- Stereo Smile Test II (Stereo Optical)
- Retinomax 2 Autorefractor (Right Manufacturing Inc.)
- SureSight Vision Screener (Welch Allyn)

Each child is screened on each of these tests twice, once by a pediatric nurse screener and once by a lay screener. As in Phase I, all children completing the screening tests will undergo a comprehensive eye examination by a licensed eye care professional masked to the results of the screening. Data collected during the eye examination will be used as the gold standard with respect to the absence or presence of the conditions targeted for detection.

The results of Phase II will indicate which screening tests administered by pediatric nurses or lay screeners accurately identify children who would benefit from a comprehensive eye examination.

Patient Eligibility

Children enrolled in Head Start are eligible to participate in Phase II of the VIP Study.

Patient Recruitment Status

Ongoing for Phase II (2003-2004).

Current Status of Study

Phase I data collection is complete. In Year 1 of Phase I (2001-2002) 1,379 children were registered into VIP, 1,257 were screened and 1,195 received a comprehensive (Gold Standard) eye examination. In Year 2 of Phase I (2002-2003), 1,724 children were registered into VIP, 1,523 were screened and 1,471 received a comprehensive (Gold Standard) eye examination. Subject enrollment and data collection for Phase II are ongoing.

Results

The study results from Phase I showed that the 11 screening tests, when administered by highly trained personnel in a controlled environment, vary widely in their performance for detecting children who have amblyopia, strabismus,

refractive error, and/or reduced visual acuity and who could benefit from a comprehensive eye examination.

Overview of Findings from Phase I

- With specificity set at 90%, sensitivities for detecting children with any VIP targeted condition were highest, and approximately equivalent for noncycloplegic retinoscopy (64%), Retinomax autorefractor (63%), SureSight Vision Screener (63%), and Lea symbols visual acuity testing (61%) among the 11 screening tests evaluated.
- Furthermore, when the sensitivity for detecting children with conditions considered the most important to detect was examined, these same 4 tests performed best: noncycloplegic retinoscopy (90%); Retinomax autorefractor (87%); SureSight Vision Screener (81%); and Lea symbols visual acuity testing (77%).
- Detection of children with amblyopia and detection of children with significant refractive error were most accurate when tests of refractive error were used, while most of the 11 tests showed similar accuracy for detection of children with strabismus.
- The tests that use static photorefraction (iScreen and MTI) were less accurate than noncycloplegic retinoscopy, the Retinomax autorefractor, and the SureSight Vision Screener.

General Summary of Findings

When the best tests were used by highly skilled personnel, approximately two thirds of children with one or more VIP targeted disorders and 90% of those children with the most important conditions were identified, while referring 10% of normal children for an eye examination (90% specificity).

Publications

The Vision in Preschoolers Study Group: Preschool Visual Acuity Screening with HOTV and Lea Symbols: Testability and Between Test Agreement. Optom Vis Sci, in press.

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Schmidt PP: Screening for the Vision Problems of Young Children. In: Moore B, ed. Eye Car for Infants and Young Children. none Butterworth-Heinemann: 175-189, 1997.

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Attachment III

UNIVERSITY EYE ASSOCIATES
Doctors of Optometry, P.A.

Dr. Steven H. Eyler
Dr. Kenneth W. Best
Dr. Magda M. Metwalli
Dr. Kristin N. Richwine
Dr. Robert C. Hamp
Dr. N. Elaine Osborne

March 15, 2006

Re: Ms. Charisse Balem
Age 4.5 years

Here is a letter I received from a mother of a pre-kindergartner who brought her daughter in for a complete vision examination after hearing that North Carolina was one of two states in the country that had a new law requiring all entering kindergartners to be examined by an optometrist or ophthalmologist before starting elementary school. Please carefully consider this child, and the hundreds of other children that will be diagnosis and properly treated, if the new " NC kids vision bill" is kept in place. The money that will be saved by the tax - payers of North Carolina with early, appropriate treatment of these potentially learning disabled children, will only supplement their 'quality-of-life' potential realized by professional, medical-eye care intervention.

Respectively Submitted,

Steven H. Eyler, O.D., F.A.A.O..

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March 14, 2006

Dear Member of North Carolina General Assembly:

I have a 4-½ year old daughter that wears glasses.

My daughter Charisse Balem had her 4-year-old well visit in the fall of 2005. Her pediatrician said I had the option of getting her eyes checked at this visit or I could wait until her next year's checkup at the age of 5 before she started kindergarten. I requested her eyes to be checked at this well visit. She passed with flying colors and I was told there were no issues with her eyes or vision. I am fortunate enough to have vision insurance, however, and with the start of the new 2006 year I decided to schedule eye exams for all of us, 2 year old daughter and 4 year old daughter included, especially since my 4 year old would be starting kindergarten this year. I did not suspect there would be any issues at all but even though my daughter's pediatrician said her eyes were fine, I felt an eye exam by a qualified eye doctor would not hurt.

Imagine my concern when I find that my daughter is farsighted with astigmatism, has 20/80 vision in one eye that happens to also be lazy and 20/50 vision in the other eye! I was just told a few months earlier by her pediatrician that her vision was fine. Her eye doctor prescribed eye glasses for her and told me that had I not brought her in at this time that a lazy eye would have been almost impossible to correct at a later age. I was very thankful in my foresight that I had decided to take my daughters to see an eye doctor. Her vision a year later could have worsened to the point of a visible lazy eye and possible delays in her reading and learning development.

I recently read an article that nearly a dozen local school boards are suing the state of NC over a new law requiring comprehensive eye exams for children entering kindergarten, arguing it violates the state constitution's mandate for free public education and it would be too expensive and unnecessary. I am dismayed that this law may not go into effect because of the costs of an exam. What about parents such as myself who have vision insurance but may not know the risks of waiting too long to take a child for an eye exam? The $65- 120 would be worth it to me to find a way to pay regardless if I had insurance or not to prevent my child from having visions problems such as 20/80 vision and a lazy eye that could affect her ability to read, learn and her quality of life. Do we want schools full of children who maybe not learning as well as they should not because they have ADD or some other developmental disorder but because they simply don't see well enough, a problem that could be addressed corrected by means of a mandatory eye exam before beginning kindergarten? If not at kindergarten for this expense, then when, for those with vision issues?

My daughter would get very frustrated when we would practice recognizing her letters and numbers and reading stories. I thought it was just because she was 4 and being contrary. But I found out that it could have been that she simply could not see letters and numbers and books clearly. In two weeks since receiving her new glasses, her vision has improved dramatically. I am so thankful for my eye doctor helping me to address my daughter's vision problems now instead of sadly finding out a year or two from now that a lazy eye could not be corrected. I sincerely hope that NC will reconsider this law.

Respectfully yours,

Crystal Wilson

Crystal Wilson
440 Riverglen Drive NW
Concord, NC 28027

Attachment IV

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,

Plaintiffs,

v.

STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,

Defendants.

AFFIDAVIT OF
DR. R. JEFFREY BOARD

I, Dr. R. Jeffery Board, being first duly sworn, do hereby state as follows:

1. My name is R. Jeffrey Board. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am a Board Certified Ophthalmologist specializing in pediatric ophthalmology. I have practiced pediatric ophthalmology for 30 years, and I have been in practice in Raleigh since 1984. Approximately eighty percent of my practice is devoted to pediatric ophthalmology and twenty percent to ocular misalignment in adults.

3. Ophthalmologists are medical doctors who attend medical school and perform a three to four year residency in ophthalmology after medical school. Pediatric ophthalmologists spend an additional one to two years in sub-speciality fellowship training. Optometrists attend four years of optometry school. They are not medical doctors, and they may not perform surgery.

4. I am familiar with the new law requiring all incoming kindergarten students to get a comprehensive eye exam from an optometrist or ophthalmologist. I strongly oppose this law because there is no legitimate medical or educational interest served by requiring a child to obtain a comprehensive eye exam before entering kindergarten at age 5.

5. Medically speaking, age 5 is the least advantageous time to detect vision disorders in young children.

6. Age 3 to age 3½ is the best time to detect amblyopia, or "lazy eye," the most serious childhood eye problem. Untreated, this may result in permanent loss of vision in one eye. Amblyopia is often treated by putting a patch over the "good" eye, which forces the child to use the amblyopic eye. It is crucial to treat amblyopia by this age, as it is still more responsive to treatment, and permanent visual loss is therefore less likely.

7. It is well-established that there is no correlation between amblyopia and academic performance. Even if a child enters kindergarten with undetected amblyopia, this condition

should not interfere with the child's learning. The child's "good" eye will compensate and allow the child to see well enough to perform academic tasks.

8. Myopia, or "near-sightedness," is the most common visual problem in childhood. Myopia results from an elongated eye, and it generally does not appear in children until ages 6 to 12. Less than 10% of myopia develops before age 5. Once myopia is detected, it can be corrected with glasses. Unlike amblyopia, failure to correct myopia does not result in permanent damage to a child's vision. Because of this, routine exams to detect myopia are not recommended unless the child has visual complaints, has symptoms of poor visual acuity, or fails a vision screening.

9. A third, and less common, eye problem in children is hyperopia, which is the optical opposite of myopia. Hyperopia is present in children because they have small, short eyes. As their eyes grow, the hyperopia tends to improve. Until their eyes mature, most children can compensate for hyperopia by using their natural ability to focus. Only children with significant hyperopia or other related disorders – less than 5% of children – will need glasses. However, a 2004 study by Dr. Sean Donahue found that optometrists prescribed unnecessary glasses 35.1% of the time, ophthalmologists over-prescribed glasses 11.7% of the time, and pediatric ophthalmologists over-prescribed glasses only 1.8% of the time.

10. The comprehensive eye exam form requires a cycloplegic refraction. This involves putting powerful eye drops into a child's eyes to temporarily paralyze the focusing muscles. The child's eyes could be blurry for up to an entire day because of these drops. Cycloplegic refraction is often necessary and can be an important part of an eye exam. However, it should not be repeated if the child had a normal cycloplegic exam at age 3 or 4 and was determined to still have normal vision at age 5. The current law would require a cycloplegic

refraction even under the above circumstances. I consider this to be grossly unnecessary, and I would refuse to subject my own children to this procedure.

11. A comprehensive eye exam from an optometrist or ophthalmologist may cost up to and over $120. In contrast, vision screening can be obtained for little or no cost at county health departments.

12. Only 6% to 7% of children who are screened require a follow-up comprehensive eye examination. Vision screening ensures that costly comprehensive eye exams are not needlessly required of all children.

13. I was a member of two task forces initiated by the General Assembly in 1995 and in 2004, charged with the responsibility of examining the effectiveness of vision screening for young children. Both task force reports recommended vision screening over comprehensive eye exams.

14. A vision screening has proved effective in detecting most eye problems in children. It is crucial that North Carolina expand vision screening in the preschool age group (ages 3 to 4) to detect amblyopia. Prevent Blindness is a national leader in these screening efforts. I am proud to have been past president of this non-profit organization and I am proud of the job they are doing in screening approximately 500,000 preschool and elementary school children. Prevent Blindness also administers the Vision Services Plan, which provides vouchers for free eye exams for those children who need one.

15. Vision screening is the best solution for ensuring that children with eye problems are detected and treated. These exams are effective, available at little or no cost, and widely available. Comprehensive eye exams for children are costly and for the vast majority of preschool children, are medically unnecessary.

16. Requiring that all children have a comprehensive eye exam before entering kindergarten does not make good medical or economic sense. It implies that this is the best time to expend resources for an eye exam, when, in reality, it is the worst. To me, it makes about as much sense as requiring an EKG for all students before they can participate in school sports. A very small percentage of students will have problems that need immediate treatment, but requiring that all students be subjected to the cost and inconvenience of the exam is simply not justified to find the few children with health problems. At least in that case, the attempt would be to detect a life-threatening condition. There is no evidence that by performing a comprehensive eye exam six months before kindergarten, we are detecting vision-threatening conditions or conditions that would permanently detract from a child's academic performance.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 8th day of March 2006

Dr. R. Jeffrey Board

Wake County
North Carolina

Sworn to and subscribed before me this day by R. Jeffrey Board. I have personal knowledge of the identity of R. Jeffrey Board.

Date: 3-8-2006

EDITH SOKOLOVE, Notary Public
My commission expires: 9-24-2008

(Official Seal)

STATE OF NORTH CAROLINA

COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION, Plaintiffs, v. STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction, Defendants.	**AFFIDAVIT OF DR. PETER MORRIS**

I, Dr. Peter Joseph Morris, being first duly sworn, do hereby state as follows:

1. My name is Peter Joseph Morris. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am a pediatrician and epidemiologist. I have been a practicing pediatrician for 25 years. I am currently the Medical Director of Wake County Human Services and the President of the North Carolina Pediatric Society.

3. I am familiar with the requirements of the new law that requires all students entering kindergarten to obtain a comprehensive eye exam from an optometrist or ophthalmologist prior to admission.

4. A comprehensive eye exam for every kindergarten child is medically unnecessary and a waste of public and private resources.

5. As an epidemiologist, I am trained in assessing measures used to detect and treat disease in large populations.

6. Requiring comprehensive eye exams for every kindergarten student is a drastic and inappropriate measure to deal with what is, in reality, a very low incidence of vision disorders in young children.

7. Doctors simply do not test each person for every conceivable medical problem. Decisions to screen and test large populations should be made by carefully weighing the resources expended against the expected health benefit.

8. A comprehensive eye exam for every five-year-old is high cost and offers no significant health benefit for the vast majority of children.

9. The United States Preventative Task Force reports that only 5% to 10% of children have developed a vision problem by age 5. The majority of these children will have their problem detected in physical examinations performed during well child visits required at regular and recommended intervals. Few children will have undiagnosed problems six months

before entering kindergarten, because they have received five years of pediatric check-ups and age appropriate examinations and vision screenings.

10. Vision screening works. The recommended periodic examinations and screenings, including the kindergarten health assessment, detect most abnormalities. The kindergarten vision screening is effective and cost-efficient because it reliably detects children who need referral for a comprehensive eye exam, and prevents other children from having to get an unnecessary comprehensive exam.

11. Vision screenings are performed at every well child visit from birth onward.

12. North Carolina is also fortunate to have Prevent Blindness North Carolina, which is the nation's largest non-profit screening effort. Prevent Blindness trains volunteers who annually screen 500,000 children across the state in kindergarten through fifth grade.

13. The kindergarten health assessment that every child receives before entering kindergarten includes a vision screening component, and assures that every kindergarten student will have his or her vision assessed.

14. The kindergarten health assessment is widely available at little or no cost from county health departments across North Carolina. At the county health departments, no one is denied a service based on inability to pay. A child does not need to have a social security number or proof of citizenship, unless the child is applying for a federal benefit at the same time.

15. On the other hand, a comprehensive eye exam is expensive, costing anywhere from $60 to $150. Medicaid and the $2 million dollar assistance fund established by the new law are not available to help undocumented children pay for an expensive comprehensive eye exam. Many other families who are not eligible for public assistance do not have private vision insurance to cover the cost of this exam.

16. The vision screening component of the kindergarten health assessment includes a physical examination of the eye and a test for visual acuity at distance. These tests will detect the most common childhood vision problems in children whose visual problems have not already been identified during previous periodic health examinations.

17. Best practice places screenings before comprehensive examinations. Epidemiology, or population based medicine, balances the seriousness of the condition with the cost and ease of earlier detection to make recommendations regarding best practices to detect the condition without missing cases (false negatives) or referring too many non-cases (false positives). The American Academy of Pediatrics, the American Academy of Family Physicians, and the Preventive Services Task Force of the US Public Health Service all recommend periodic vision screening at well child visits from birth through childhood, not comprehensive eye exams, as best practice to detect visual abnormality in children.

18. Age 5 is late to detect amblyopia, a serious childhood vision problem, commonly known as "lazy eye." Amblyopia should and can be identified by physical examination before age 3.

19. Age 5 is early to detect myopia, or "near-sightedness." Myopia typically does not develop until age six or later, so an eye exam at age 5 will do nothing to detect this problem.

20. The comprehensive eye exam wastes scarce medical resources, is not best medical practice, and places an unnecessary financial burden on insured and uninsured families alike. From an epidemiological and medical perspective, vision screening at well child visits, including the kindergarten health assessment, is the best choice: it is effective, it is available at little or no cost, and it is widely available.

21. Pediatricians should reinforce our best practice for vision screening, but we cannot support a required comprehensive vision examination for all children entering kindergarten.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 7 day of March 2006

Peter Morris MD MPH

Dr. Peter Morris

Wake County
North Carolina

Sworn to and subscribed before me this day by Peter Morris. I have personal knowledge of the identity of Peter Morris.

Date: 3/7/06

Paulette B. Bellamy, Notary Public

My commission expires: 05/06/07

(Official Seal)

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION, Plaintiffs, v. STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction, Defendants.	)	**AFFIDAVIT OF DR. W. ZACHERY BRIDGES**

I, Dr. W. Zachery Bridges, being first duly sworn, do hereby state as follows:

1. My name is W. Zachery Bridges. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am an ophthalmologist in private practice in Asheville, North Carolina. I am the current president of the North Carolina Society of Eye Physicians and Surgeons.

3. I have reviewed the contents of the Affidavit of Dr. Charles Willson. I am knowledgeable about the bases for the opinions and conclusions stated in Dr. Willson's Affidavit, and I adopt these opinions and conclusions for the purposes of this Affidavit.

4. The North Carolina Society of Eye Physicians and Surgeons agrees that comprehensive eye exams are medically unnecessary and economically inappropriate. We strongly support medically appropriate and cost-effective eye health services, including the State's current system of quality vision care for children.

5. The North Carolina Society of Eye Physicians and Surgeons strongly opposes the new comprehensive eye exam law.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 7th day of March 2006.

Dr. W. Zachery Bridges

Buncombe County
North Carolina

Sworn to and subscribed before me this day by W. Zachery Bridges. I have personal knowledge of the identity of W. Zachery Bridges.

Date: 03/07/06

Mary B. Lamy
Mary B. Lamy, Notary Public
My commission expires: 04/30/07

(Official Seal)

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION, Plaintiffs, v. STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction, Defendants.	**AFFIDAVIT OF DR. CYNTHIA HAMPTON**

I, Dr. Cynthia Hampton, being first duly sworn, do hereby state as follows:

1. My name is Cynthia Hampton. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am a general ophthalmologist and have been in practice in Henderson, North Carolina for 15 years. I am a member of the American Academy of Ophthalmology and a past president of the North Carolina Society of Eye Physicians and Surgeons.

3. Both of these organizations oppose the new law requiring mandatory comprehensive eye exams for children prior to entering kindergarten.

4. Ophthalmologists are medical doctors who specialize in eye health. Based upon our training and experience, we believe that these mandated eye exams are economically wasteful and medically unnecessary.

5. Performing full eye exams on children just prior to starting kindergarten is medically unnecessary and unadvisable because this is not the most opportune time in visual development to diagnose and treat the most common eye disorders in children.

6. The two most common eye disorders in children are amblyopia and myopia. Amblyopia, commonly referred to as "lazy eye," is a condition that should be diagnosed and treated by age 3 to 3½. Waiting until age 5 to detect this disorder will generally be too late for effective treatment. The most common eye disorder is myopia or "near-sightedness." Myopia generally develops between ages 6 and 12. An eye exam at age 5 will do nothing to detect myopia that develops in later years.

7. Screening a child's visual status is and should continue to be an integral part of a child's overall health assessment starting at birth and continuing throughout the child's development. Vision screenings are cost efficient and can be performed almost anywhere. Routine vision screening has been very successful in states such as North Carolina, which has the country's largest non-profit vision screening program and has been cited as a prototype for other states. Thorough, yet cost-

effective vision screening, identifies children who need more comprehensive follow up exams, thus saving health care dollars for children who need it the most.

8. In 2004, a multi-disciplinary task force appointed by the General Assembly that included medical doctors as well as optometrists studied the adequacy and effectiveness of vision screening for children enrolled in North Carolina's Medicaid program. The Task Force reported back to the Legislature that the most reasonable and responsible way to improve vision services for North Carolina children is to expand the vision screening component of the existing Kindergarten Health Assessment. The Task Force did not recommend mandatory comprehensive eye examinations for kindergarten-age children.

9. Medical policy, especially as it relates to pediatric vision care, should be shaped with the professional counsel of medical doctors. Organized ophthalmology was never consulted about the new eye exam law because it was inserted into the budget bill without public debate.

10. The eye exam mandate creates a financial hardship for parents and taxpayers. Had ophthalmologists been asked, we would have advocated for routine vision screening, performed in a child's medical home or by a professionally trained screener as a more appropriate first step toward making sure every child successfully sees their way to adulthood.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 6th day of March 2006

Cynthia A Hampton MD
Dr. Cynthia Hampton

Vance County
North Carolina

Sworn to and subscribed before me this day by Cynthia Hampton. I have personal knowledge of the identity of Cynthia Hampton.

Date: 3-6-2006

Dianne Pruett
_____, Notary Public
My commission expires: 8-4-2006

(Official Seal)

STATE OF NORTH CAROLINA | SUPERIOR COURT DIVISION

COUNTY OF WAKE | 06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION, Plaintiffs, v. STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction, Defendants.	**AFFIDAVIT OF MARCIA BRANTLEY**

I, Marcia Brantley, being first duly sworn, do hereby state as follows:

1. My name is Marcia Brantley. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am Preschool Program Director for Prevent Blindness North Carolina in Raleigh, North Carolina. I have been in this position for approximately five years.

3. Prevent Blindness North Carolina is a nonprofit health agency that delivers direct service programs designed to preserve sight through screening, publications, safety, education, information and referral through volunteer efforts.

4. As part of its activities, Prevent Blindness North Carolina administers the voucher program for Vision Services Plan, a national organization that provides vouchers for free eye exams for eligible children.

5. As part of our responsibilities under this project, I undertook to collect data on the number of North Carolina counties that do not have licensed optometrists or ophthalmologists.

6. To collect this data, I contacted county health departments by telephone to find out whether the department had an optometrist or ophthalmologist. I also asked the staff if they knew of any optometrists or ophthalmologists in their counties.

7. I consulted the database of optometrists licensed by the North Carolina State Board of Examiners in Optometry to practice in the State of North Carolina. I received an electronic copy of this list from Janice Peterson, an administrative secretary at the North Carolina State Board of Examiners in Optometry. The list states the county in which each North Carolina optometrist is located. The list is attached as **Exhibit A.**

8. I also consulted the Licensee Search System from the North Carolina Medical Board, which licenses medical doctors, including ophthalmologists, in North Carolina. The search system is available at www.ncmedboard.org. I used the search system to search for ophthalmologists in each city in the North Carolina counties for which I had information there were no ophthalmologists or optometrists.

9. I also consulted the Membership Directory for the North Carolina Medical Society, available at www.ncmedsoc.org. This list reveals 308 ophthalmologists practicing in North Carolina. I used this list to perform another search for ophthalmologists in each city in the counties for which I had information there were no ophthalmologists or optometrists.

10. I began this process in early February 2006 and finished it in late February 2006.

11. As a result of this process, I have confirmed that seven North Carolina counties do not have a licensed optometrist or ophthalmologist. These counties are: Camden, Gates, Hyde, Jones, Northampton, Perquimans, and Tyrrell.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 6 day of March 2006

Marcia Brantley
Marcia Brantley

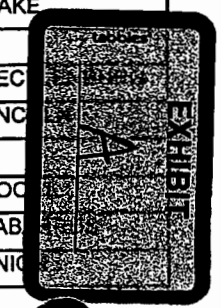
Wake County
North Carolina

Sworn to and subscribed before me this day by Marcia Brantley. I have personal knowledge of the identity of Marcia Brantley.

Date: March 6, 2006 Raquel K. Martin
, Notary Public
My commission expires: July 21, 2007

(Official Seal)

NSE_NU	RST_NAM	LE_	LAST_NAME	ERA	STATUS	F_PHONE_NUM	ADDRESS_	PREF_ADDRESS_LINE_2	DDRES	EF_ADDRESS_C	REF_ADDRESS_STA	DDRESS_ZIP	F_ADDRESS_COU
0775	Forrest	L.	Abernathy	Jr	Active	(828) 837-2286	159 Hiawass	PO Box 680		Murphy	NORTH CAROLINA	28906	CHEROKEE
0497	Edwin	L.	Adams		Active	(919) 734-8998	1318 C. Way			Goldsboro	NORTH CAROLINA	27534	WAYNE
0947	John	I.	Adams		Active	(910) 739-3323	Adams Opto	4811 Fayetteville Rd		Lumberton	NORTH CAROLINA	28358	ROBESON
1175	Rick	S.	Adams		Active	(252) 443-7011	eyecarecente	3044 Sunset Ave.		Rocky Mount	NORTH CAROLINA	27804	NASH
0770	William	C.	Adams		Active	(919) 894-2001	Doctors Visi	304 E. Main Street	P.O. B	Benson	NORTH CAROLINA	27504	JOHNSTON
0940	William	J.	Adams		Active	(252) 473-2155	Dare Vision	PO Box 879 Hwy 64 S		Manteo	NORTH CAROLINA	27954	DARE
1885	Joyce	N.	Adeleke		Active	(704) 720-7363	150 Concord			Concord	NORTH CAROLINA	28027	CABARRUS
1975	Allan	R.	Adkins		Active	(336) 884-3937	eyecarecente	Oak Hollow Mall	921 Ea	High Point	NORTH CAROLINA	27260	
0808	Barry	L.	Adler		Active	(919) 929-7111	Adler Eye As	861 Willow Dr.		Chapel Hill	NORTH CAROLINA	27514	ORANGE
1821	Dana	R.	Agnes		Active	(704) 372-5332	Eye Care Cli	1960 Randolph Rd.		Charlotte	NORTH CAROLINA	28207	MECKLENBURG
1433	Bonnie	E.	Aiken		Active	(336) 768-4140	Hawthorne E	2821 Maplewood Avenue		Wiston-Salem	NORTH CAROLINA	27103	
1211	Thomas	A.	Akers	II	Active	(252) 443-7011	eyecarecente	3044 Sunset Ave.		Rocky Mount	NORTH CAROLINA	27804	NASH
1849	Kirsten		Albrecht		Active	(704) 782-0677	Southern Ey	584 N Church St		Concord	NORTH CAROLINA	28025	CABARRUS
1015	Charles	H.	Aldridge	Jr	Active	(828) 682-2104	419 E. Main	PO Box 218		Burnsville	NORTH CAROLINA	28714	YANCEY
1037	David	E.	Alexander		Active	(828) 437-2950	Eyecare Spe	149 B West Parker Rd.		Morganton	NORTH CAROLINA	28655	BURKE
1038	Michael	W.	Alexander		Active	(704) 482-2020	Morganton E	1622 East Marion St.		Shelby	NORTH CAROLINA	28150	CLEVELAND
0898	Robert	F.	Allen		Active	(252) 492-9559	1904 Grahar			Henderson	NORTH CAROLINA	27536	VANCE
1284	Ronald	G.	Amaker		Active	(828) 757-2816	Dr. Ronald G	845-R Blowing Rock Blvd.		Lenoir	NORTH CAROLINA	28645	CALDWELL
1077	David	R.	Anderson		Active	(252) 823-8552	Tarboro Clin	2807 Main Street	P.O. B	Tarboro	NORTH CAROLINA	27888	EDGECOMBE
1609	Jill	A	Anderson		Active	(920) 748-1497	Northeast W	1080 Fond du Lac Street		Ripon	WISCONSIN	54971	
1610	Julie	B.	Anderson		Active	(913) 390-1199	20617 W. 95			Lenexa	KANSAS	66220	
1078	Leslie	M.	Anderson		Active	(704) 545-8831	11235 Lawye	P. O. Box 23176		Charlotte	NORTH CAROLINA	28227-0272	MECKLENBURG
1742	Teri	D.	Anderson		Active	(336) 765-5788	eyecarecente	3320 Silas Creek Parkway	Suite 5	Winston-Salem	NORTH CAROLINA	27103	FORSYTH
1484	Timothy	P.	Anderson		Active	(828) 692-2593	Professional	3450 Asheville Hwy		Hendersonville	NORTH CAROLINA	28791	HENDERSON
1825	Larry	Ken	Andreo	M.D.	Active	(919) 786-0141	Fox Eye Car	4325 Glenwood Avenue		Raleigh	NORTH CAROLINA	27612	WAKE
1655	W. Alex		Appanaitis		Active	(336) 924-9121	Old Town Fa	3800 Reynolda Rd.	Suite 3	Winston-Salem	NORTH CAROLINA	27106	FORSYTH
1474	Melanie	S.	Archibald		Active	(205) 969-8100	Michelson La	327 Summit Blvd.		Birmingham	ALABAMA	35243	
1313	Laurie	A.	Arcolano		Active	(910) 484-3030	Tallywood O	226-B Tallywood Shopping Ce		Fayetteville	NORTH CAROLINA	28303	CUMBERLAND
1696	Paulsen	C.	Arnold		Active	(919) 266-3700	Arnold Eye C	4019 Village Park Drive		Knightdale	NORTH CAROLINA	27545	WAKE
1144	Norman	J	Arons		Active	(239) 936-8841	Sterling Opti	4125 Cleveland Avenue		Ft. Myers	FLORIDA	33901	
1611	Robert	C.	Askary		Active	(704) 588-5210	eyecarecente	8506-A South Tryon Street		Charlotte	NORTH CAROLINA	28273	MEC
1850	John	M.	Assell		Active	(704) 822-9920	Advanced Fa	7547 Waterside Loop Road	Suite A	Denver	NORTH CAROLINA	28037	LINC
1502	Annette	J	Astuto		Inactive	(253) 589-6626	4280 Lincoln			Lakewood	WASHINGTON	98439	
1486	William Sc		Athans		Active	(910) 692-3937	Spectrum Fa	DBA Doctors Vision Center	160 Fo	Pinehurst	NORTH CAROLINA	28374	MOC
1271	J. Eric		Atkinson		Active	(704) 938-1135	608 Jackson	PO Box 1244		Kannapolis	NORTH CAROLINA	28082	CAB
0801	Charles	B.	Aycock		Active	(704) 283-2179	Aycock Eye	120 East Phifer St.		Monroe	NORTH CAROLINA	28110	UNI



STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,

Plaintiffs,

v.

STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,

Defendants.

AFFIDAVIT OF
DR. ANN T. DENLINGER

I, Dr. Ann T. Denlinger, being first duly sworn, do hereby state as follows:

1. My name is Ann T. Denlinger. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am the Superintendent of the Durham Public Schools and have held this position

for the past 9 years. I have been a teacher, school administrator and central office administrator in the Wake County Schools and the Superintendent of the Wilson County Schools.

3. I am aware of the new legislation that requires every child to have a comprehensive eye exam before entering public kindergarten, beginning with the upcoming school year.

4. I fully support the decision of my school board to join this lawsuit to seek the repeal of this legislation.

5. In my opinion, the requirement that every child have an eye exam as a condition of entering kindergarten is fundamentally wrong. This requirement will not improve educational outcomes for our students. It will do just the opposite.

6. As discussed in the affidavit of Stacey Wilson-Norman, Executive Director of Elementary Programs for our school system, based on our knowledge of our school population, we are certain that many of our children will not have the necessary eye exam by the time school starts. I also believe that, because of the cost of the eye exam, many of our children will not have obtained the exam even months into the school year.

7. Many of our Hispanic and lower to middle income families will not qualify for public assistance and will not have insurance for this exam. These families simply cannot afford an expensive eye exam.

8. Also, in spite of our efforts to promote early registration, many of our families will not learn about the eye exam requirement until the week before school starts. Even if they could afford the exam or qualify for public assistance, these families will not be able to get a doctor's appointment in time to enroll their child on the first day of school.

9. The start of kindergarten is a critical time in the personal and educational life of a

child. Starting school is a major adjustment for small children, especially those who have no prior school experience. We have many children who come to us without basic pre-school skills. These are the children who are most likely to be delayed or prevented from admission because they have not received the eye exam. They will be denied the opportunity to participate in the important process of kindergarten orientation. They will enter school late or not at all and suffer educationally as a result.

10. We know from the medical community that this eye exam is not necessary. As a life-long educator I am appalled that the legislature is requiring local school systems to turn children away from school because they have not had an unnecessary and costly medical procedure.

11. I have spent my entire career working in public schools systems in North Carolina. The vision care of students has never been a major impediment to successfully educating our students. What is most important is that children come to school from the first day so they can receive their education.

12. The eye exam legislation puts local school officials in the position of choosing between doing what is educationally and constitutionally correct and what is unreasonably, legislatively mandated. In June I will retire after spending forty years as a public school educator. I am glad that I will not be faced with making this impossible choice. This law should be repealed so that no North Carolina educator will be required to do so.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 7th day of March 2006

Ann T. Denlinger

Dr. Ann T. Denlinger

State of North Carolina
County of Alamance

Sworn to and subscribed before me this day by Ann T. Denlinger. I have personal knowledge of the identity of Ann T. Denlinger.

Date: March 7, 2006

Gwendolyn W. Parker, Notary Public

My commission expires: 3/30/2010

(Official Seal)

OFFICIAL SEAL
Notary Public, North Carolina
County of Alamance
GWENDOLYN W. PARKER
My Commission Expires Mar. 30, 2010

201236

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION, Plaintiffs, v. STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction, Defendants.	)	**AFFIDAVIT OF DUANE H. KIRKMAN**

I, Duane H. Kirkman, being first duly sworn, do hereby state as follows:

1. My name is Duane H. Kirkman. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am Superintendent of Hickory City Schools. I have been in this position for 6 years, and I was previously an associate superintendent in Hickory City Schools for 16 years.

3. I am aware of the requirements of the new law requiring all entering students to obtain a comprehensive eye exam from an optometrist or ophthalmologist before they can start kindergarten.

4. Hickory City Schools expects that around 404 kindergarten students will seek to enroll in our five elementary schools this year.

5. Hickory City Schools has a large population of poor students. 53% of our students receive free and reduced lunches, which means that their family incomes are within 130% to 185% of the federal poverty guidelines.

6. Hickory City Schools also has a large concentration of immigrant students, and English is the second language for 19% of our students. This population is largely Hispanic and Hmong.

7. These families do not have the resources to obtain a costly comprehensive eye exam.

8. The children of immigrants will have special difficulties in getting the eye exam. Parents who speak limited or no English will have difficulty understanding the requirements and negotiating an unfamiliar environment to get care from the correct providers. Many of these families do not have transportation.

9. I have seen the Early Childhood Vision Care eligibility form that must be completed and submitted in order for a student to receive financial assistance, which is attached as Exhibit A. The form requires a social security number as well as complex wage and tax

information. It is likely that a significant portion of our families, especially immigrant families, will be unable to complete this form.

10. Due to the expense of the eye exam and other obstacles in obtaining it, we expect that a large number of our entering kindergarten students will not receive this exam by the first day of school, or even within six months of starting school.

11. When the first day of kindergarten arrives and many kindergarten children have not obtained the required eye exam, Hickory City School administrators will be in the untenable position of either enrolling students in violation of the new eye exam law or turning these children away in violation of our legal duty to provide a free public education to all children.

12. Given that the mandatory comprehensive eye exam serves no valid public health purpose and will prevent many disadvantaged children from attending kindergarten, Hickory City Schools opposes the new requirement.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 6th day of March 2006

Duane H. Kirkman

Catawba County
North Carolina

Sworn to and subscribed before me this day by Duane H. Kirkman. I have personal knowledge of the identity of Duane H. Kirkman.

Date: 3.6.06

MARY C. DeJUETTE, Notary Public
My commission expires: 3.30.2009

(Official Seal)

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,	)	
Plaintiffs,	)	**AFFIDAVIT OF NELSON SMITH**
v.	)	
STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,	)	
Defendants.	)	

I, Nelson Smith, being first duly sworn, do hereby state as follows:

1. My name is Nelson Smith. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am Superintendent of Tyrrell County Public Schools. I have been in this position for six years.

3. Tyrrell County Public Schools is a small school system, with one elementary school, one middle school, and one high school.

4. Each year, Tyrrell County Schools ensures that 100% of children complete the Kindergarten Health Assessment, which includes a vision screening. The health assessment is free at the county health department.

5. Our teachers also refer children to the school nurse for additional screening as necessary. Because we are a small school system, we are able to detect children with eye problems and make sure they receive care.

6. In past years we have also brought in the health department to perform screenings on all children in grades 1 through 5, because we understand the importance of consistent vision screening to detect serious eye problems such as amblyopia.

7. I am familiar with the requirements of the new law requiring all entering students to obtain a comprehensive eye exam from an optometrist or ophthalmologist before they can start kindergarten.

8. Tyrrell County Schools expects that 53 students will enroll in kindergarten this year.

9. There is no optometrist or ophthalmologist practicing in Tyrrell County. In order to obtain an exam, many families will have to drive up to fifty miles to Plymouth or Nags Head.

10. Tyrrell County is one of the poorest counties in North Carolina, with a median household income of around $26,000.

11. Many of the parents of our students are hourly employees who cannot afford the cost of a $65 to $120 eye exam. On top of this unnecessary and significant expense, these parents cannot afford to take half a day or a day off work to take their children out of the county for an eye exam.

12. Some of our children do not possess a social security number and therefore will not be eligible for assistance through Medicaid or through the $2 million dollar fund established as part of the Governor's Vision Care Program.

13. Tyrrell County Schools is the largest employer in the county, followed by the North Carolina Department of Correction's Tyrrell County Prison Work Farm. The State Employees Health Plan, which provides coverage for these employers, does not provide coverage for a comprehensive eye exam.

14. Due to the expense and the lack of availability, we anticipate that 30% to 40% of our entering kindergarten students will not have obtained a comprehensive eye exam by the first day of school.

15. In Tyrrell County, 75% to 80% of our entering kindergarten students are developmentally delayed. These students need to be in kindergarten on the first day of school and every day thereafter.

16. Tyrrell County Schools will not turn these students away, although this will mean violating the new eye exam law.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the third day of March 2006

Nelson W Smith

Nelson Smith

Tyrrell County

North Carolina

Sworn to and subscribed before me this day by Nelson Smith. I have personal knowledge of the identity of Nelson Smith.

Date: 3-3-06

Pandora D. College

_____, Notary Public

My commission expires: Nov. 30, 2008

(Official Seal)

STATE OF NORTH CAROLINA

COUNTY OF WAKE

SUPERIOR COURT DIVISION
06 CVS 002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,

Plaintiffs,

v.

STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,

Defendants.

AFFIDAVIT OF RONALD A. KLEPCYK

1. My name is Ronald A. Klepcyk. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am employed by Elon University. My position is Director of Human Resources. I have been employed by Elon University for 28 years.

3. My company is a major employer in Alamance County. The company has approximately 986 employees.

4. In my position, I am familiar with the benefits provided to employees of my company. My company offers health insurance for employees. This health insurance does not provide coverage for a comprehensive eye exam.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 6th day of March 2006

Ronald A Klepcyk

STATE OF NORTH CAROLINA

COUNTY OF Alamance

Sworn to and subscribed before me this day by Ronald A. Klepcyk I have personal knowledge of the identity of Ronald A. Klepcyk

Date: March 6, 2006

Nancy Thompson, Notary Public

My commission expires: 4/21/07

(Official Seal)

STATE OF NORTH CAROLINA

COUNTY OF WAKE

SUPERIOR COURT DIVISION
06 CVS 002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,	)	
Plaintiffs,	)	**AFFIDAVIT OF GWYNNE WARREN**
v.	)	
STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,	)	
Defendants.	)	

1. My name is Gwynne Warren. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am employed by ARMC Health Care. My position is Benefits Coordinator. I have been employed by ARMC HealthCare for 10 years.

3. My company is a major employer in Alamance County. The company has approximately 1600+ employees.

4. In my position, I am familiar with the benefits provided to employees of my company. My company offers health insurance for employees. This health insurance does not provide coverage for a comprehensive eye exam.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 3 day of March 2006

Gwynne Warren, CBP

STATE OF NORTH CAROLINA

COUNTY OF Alamance

Sworn to and subscribed before me this day by Gwynne Warren. I have personal knowledge of the identity of Gwynne Warren.

Date: 3-3-2006

Mandy L. Parham

Mandy L. Parham, Notary Public

My commission expires: 4-5-2006

(Official Seal)

MANDY L. PARHAM NOTARY PUBLIC ALAMANCE COUNTY, NC

STATE OF NORTH CAROLINA
COUNTY OF WAKE

SUPERIOR COURT DIVISION
06-CVS-002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,

Plaintiffs,

v.

STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,

Defendants.

AFFIDAVIT OF DR. CHARLES WILLSON

I, Dr. Charles Willson, being first duly sworn, do hereby state as follows:

1. My name is Charles Willson. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am a pediatrician and practiced for nineteen years in Greenville, North Carolina. I am currently a clinical professor of pediatrics at East Carolina University School of Medicine. I am the current president of the North Carolina Medical Society.

3. The North Carolina Medical Society opposes the new law requiring all students entering public kindergarten to obtain a comprehensive eye exam.

4. There is no evidence to support the premise that comprehensive eye examinations by ophthalmologists or optometrists are necessary for all children in order to detect serious eye problems, nor do data exist demonstrating that these exams result in a better long-term outcome than traditional methods of vision screening.

5. In fact, evidence suggests that a combination of screening by pediatricians, school nurses and volunteers is a very effective way to detect significant eye problems.

6. Critics of screening cite the relatively low sensitivity of a single screening encounter as evidence that comprehensive exams are needed; however, this argument is invalid because most children have more than one screening encounter during the first several years of life, and the sensitivity of multiple screens over time is much higher.

7. The most common types of eye problems that are detected by screening or by comprehensive examinations are amblyopia and nearsightedness. Amblyopia, or "lazy eye," is decreased vision in one eye due to an eye misalignment or a difference in focus between the eyes. Amblyopia is best detected and responds best to treatment in the first 2-3 years of life, so age 5 is not the optimal time to test for it.

8. Amblyopia does not cause learning disabilities, so the argument that it is important to detect it before school starts in order to allow children to learn is invalid.

9. Nearsightedness results in blurry vision at distance, and it does not interfere with

learning to read. Children who have trouble seeing the board at school will almost always complain or squint or move closer, prompting a parent or teacher to obtain an examination. Early detection of nearsightedness makes no difference in its outcome.

10. A program of comprehensive eye examinations for all children is not without harm. One study showed that performing comprehensive eye examinations on normal children will result in a significant number of them receiving glasses unnecessarily. Also, many parents will be told by optometrists that their child needs "vision therapy," a controversial, expensive treatment that is not accepted by the mainstream medical community, including most ophthalmologists and pediatricians. Finally, many children at age 5 become scared and cry when receiving the eye drops that are necessary to complete comprehensive examinations.

11. A requirement for comprehensive eye exams for all kindergarten children is medically unnecessary and inappropriate. The North Carolina Medical Society strongly opposes the new comprehensive eye exam law.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 7 day of March 2006.

Dr. Charles Willson

Orange
~~Wake~~ County
North Carolina

Sworn to and subscribed before me this day by Charles Willson. I have personal knowledge of the identity of Charles Willson.

Date: March 7, 2006 Lisa H. Elliott, Notary Public

My commission expires: 4-11-2009

(Official Seal)

STATE OF NORTH CAROLINA

COUNTY OF WAKE

SUPERIOR COURT DIVISION
06 CVS 002544

NORTH CAROLINA SCHOOL BOARDS ASSOCIATION, ALAMANCE-BURLINGTON BOARD OF EDUCATION, BUNCOMBE COUNTY BOARD OF EDUCATION, CURRITUCK COUNTY BOARD OF EDUCATION, DURHAM PUBLIC SCHOOLS BOARD OF EDUCATION, HICKORY CITY BOARD OF EDUCATION, LENOIR COUNTY BOARD OF EDUCATION, NEWTON-CONOVER CITY BOARD OF EDUCATION, PERSON COUNTY BOARD OF EDUCATION, TYRRELL COUNTY BOARD OF EDUCATION, WAKE COUNTY BOARD OF EDUCATION, WINSTON-SALEM/FORSYTH COUNTY BOARD OF EDUCATION,	)	
Plaintiffs,	)	**AFFIDAVIT OF STACEY WILSON NORMAN**
v.	)	
STATE OF NORTH CAROLINA, MICHAEL F. EASLEY, Governor of the State of North Carolina, in his official capacity; CARMEN HOOKER ODOM, Secretary of the North Carolina Department of Health and Human Services, in her official capacity; DR. H. MICHAEL JOHNSON, Chairman of the Governor's Commission on Early Childhood Vision Care, in his official capacity; JUNE ATKINSON, State Superintendent, North Carolina Department of Public Instruction,	)	
Defendants.	)	

I, Stacey Wilson Norman, being first duly sworn, do hereby state as follows:

1. My name is Stacey Wilson Norman. I am over 21 years of age, and I am in all respects legally competent and duly authorized to make this Affidavit. I have personal knowledge of each fact contained in this Affidavit and each such fact is true and correct.

2. I am the Executive Director of Elementary Schools for the Durham Public Schools. Before taking this position, I was the principal of Merrick-Moore Elementary School in Durham. Prior to coming to Durham, I was an elementary school teacher, curriculum specialist and assistant principal in the Wake County Public Schools.

3. I am aware of the recent legislation that requires that all public school kindergarten students have a comprehensive eye exam before they enroll in school, starting with the 2006-2007 school year.

4. Based on my many years of experience as an elementary educator, I am certain that many of our students, for a variety of reasons, will not have the required eye exam in time for the first day of school and our school principals will be forced to turn these children away.

5. Approximately 3,000 kindergarten students enrolled in Durham Public Schools last year and we anticipate an increase in 2006. A large percentage of our students are low income; last year 42% qualified for free or reduced lunch (F&R). We also have a significant number of Hispanic students whose parents speak little or no English. Many of these families do not have insurance and will not qualify for Medicaid or the Governor's Eye Care Program funds.

6. Kindergarten registration begins each year in the spring. This year it will begin on April 3. During the registration process we inform parents about the kindergarten health assessment and immunizations that are required for enrollment. This year we will also have to tell them that their kindergarten children must have a comprehensive eye exam before they can start school.

7. As part of the registration process we often inform parents that the health assessment and immunizations can be obtained at the public health department at no cost. Because the health department will not provide the comprehensive eye exam, we are gathering information about the optometrists and ophthalmologists in our area who can conduct these exams and the cost of the exams. The six eye doctors contacted thus far have quoted prices ranging from $65 to $165. There are many families in Durham who simply will not be able to afford these prices and will not have public assistance to cover the costs.

8. The kindergarten registration process is well publicized in our community. In spite of our efforts to encourage early registration, in our schools with high F&R populations, it is common for up to 50% of the kindergarten students to be registered in the last three or four days before school starts. Many times these children have not had their kindergarten health assessments or immunizations, even though these services are available for free at the public health department. Under current law, families are given 30 days to complete these requirements. When they wait until the

first week of school to register, it may take weeks for them to get a doctor's appointment. Even with the grace period allowed by law, we have had to suspend students from school because they have not gotten their immunizations.

9. The comprehensive eye exam law does not have a grace period. Principals are not allowed to enroll children in kindergarten unless they receive a form, signed by an eye doctor, verifying that the child has received the required eye exam. Based on our experience with the kindergarten health assessment and immunization requirements, I am certain that there will be hundreds of kindergarten children who we will have to bar from school because they have not had the required eye exam by the first day of school. I am concerned that many poor and middle income families that do not have insurance or public assistance for these exams will simply not be able to enroll their children in public school.

10. Based on my experience, I believe that this new law will force us to turn away the very children who most need to be in school from the beginning. The first weeks of kindergarten are crucial to help our children make the transition to school. We offer a staggered entry during the first week so that the children can become acquainted with school in smaller groups. We have the children meet the principal and teacher, learn how to ride the bus, practice walking to their classrooms, learn how to open a carton of milk. Children who fail to have their eye exam on time will miss these important experiences.

11. The eye exam law will also significantly disrupt the operation of our schools. We staff and equip our classrooms and design our bus routes based upon the number of students who are properly registered on the first day of school. Given our experience with many families waiting until the week before school to register, we know that a large number of students will not be allowed to enroll on the first day. Instead, they will arrive haphazardly, as they are able to make and pay for appointments for eye exams. This unpredictable influx of students will have a devastating effect on our elementary schools. As students trickle in and increase the sizes of our classrooms, we will have to reassign children and attempt to hire teachers after school is underway. We will also have to constantly adjust bus routes to accommodate the late arriving students.

12. Under the federal special education law, the Individuals with Disabilities Education Act (IDEA), and the parallel state law, public schools are required to serve disabled students starting at age 3. In Durham Public Schools we have 155 four-year-old students who have been identified as disabled and who are receiving services. These children will be entitled to continue to receive services when school begins in August; however, under the eye exam law we are required to deny them enrollment if they have not had a comprehensive eye exam. Under these circumstances, the new law will put Durham Public Schools in direct conflict with its obligations under federal and state special education laws.

The foregoing is a true and accurate statement of my knowledge about the matters set forth herein.

This the 6th day of March 2006

Stacey Wilson-Norman
STACEY WILSON NORMAN

State of North Carolina

County of Orange

Sworn to and subscribed before me this day by Stacey Wilson Norman. I have personal knowledge of the identity of Stacey Wilson Norman.

Date: 3/3/06

Janet S. McKee
Notary Public
My commission expires: 9/26/06

Official Seal
JANET S. McKEE
Notary Public
Orange County
State of North Carolina
My Commission Expires Sept. 26, 2006

201105

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 1330

Committee Substitute Favorable 8/23/05

Third Edition Engrossed 8/23/05

Short Title: Amend Electrolysis Practice Act/Fees. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT ALLOWING THE NORTH CAROLINA BOARD OF ELECTROLYSIS EXAMINERS TO PROVIDE FOR THE LICENSURE OF LASER CLINICIANS AND LASER CLINICIAN INSTRUCTORS UPON MEETING CERTAIN REQUIREMENTS ESTABLISHED BY THE BOARD AND AUTHORIZING THE BOARD TO CHARGE FEES RELATED TO THOSE LICENSURES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 88A-2 reads as rewritten:

"**§ 88A-2. Purpose.**

The purpose of this Chapter is to ensure minimum standards of competency, to protect the public from misrepresentation of status by persons who hold themselves out to be ~~"certified electrologists",~~"licensed electrologists" or "licensed laser clinicians" and to provide the public with safe care by the mandatory licensing of ~~electrologists.~~electrologists and laser clinicians."

SECTION 2. G.S. 88A-4 reads as rewritten:

"**§ 88A-4. Unlawful practice.**

(a) ~~Effective January 31, 1994, it~~It shall be unlawful to engage in the practice of electrolysis or laser, light source, or pulsed-light treatments in this State without a license.

(b) Any person practicing laser, light source, or pulsed-light treatments in this State without being licensed by the Board shall be guilty of a Class I felony and may be assessed a civil penalty of five thousand dollars ($5,000) per offense. Any other violation of this Chapter shall be a Class 2 misdemeanor. Nothing in this subsection shall limit or prevent any licensed physician from performing or delegating to a qualified person any acts otherwise permitted by law or established by custom."

SECTION 3. G.S. 88A-3 is amended by adding the following new subdivisions to read:

"**§ 88A-3. Definitions.**

As used in this Chapter, unless the context requires otherwise:

...

(5) 'Laser clinician' means a person who engages in laser, light source, or pulsed-light treatments of skin or hair.

(6) 'Laser, light source, or pulsed-light treatments' means the use of laser or pulsed-light devices for nonablative procedures for the removal of hair.

(7) 'Laser, light source, or pulsed-light devices' means a device used in the nonablative procedure for the removal of hair."

SECTION 4. G.S. 88A-9(b) reads as rewritten:

"(b) All fees may be calculated by the Board in amounts sufficient to pay the costs of administration of this act, but in no event may they exceed the following:

(1)	Application for licensure as an electrologist	$150.00
(1a)	Initial license	150.00
(1b)	Examination or reexamination	125.00
(2)	Licensure of electrology renewal	200.00
(3)	Application for ~~certification~~ licensure as an electrology instructor	150.00
(4)	~~Certificate~~ Licensure of electrology instructor renewal	75.00
(5)	Application for certification as a ~~Board approved~~Board-approved school of electrology	500.00
(5a)	Application for licensure as a laser clinician	150.00
(5b)	Licensure as laser clinician renewal	200.00
(5b)	Application for licensure as laser clinician instructor	150.00
(5c)	Licensure of laser clinician instructor renewal	75.00
(5d)	Application for certification as a Board-approved school of laser, light source, or pulsed-light treatments	500.00
(5e)	Certificate of Board-approved school of laser, light source, or pulsed-light renewal	250.00
(6)	Certificate of ~~Board approved~~Board-approved school of electrology renewal	250.00
(6a)	Certification of out-of-state schools	100.00
(6b)	Certification of out-of-state schools renewal	75.00
(6c)	Office inspection or reinspection	100.00
(6d)	License by reciprocity	150.00
(7)	Late renewal charge	75.00
(8)	Reinstatement of expired license or certification	300.00
(9)	Reactivation of license	200.00
(10)	Duplicate license or certification	25.00."

SECTION 5. G.S. 88A-10 reads as rewritten:

"**§ 88A-10. Requirements for licensure as an ~~electrologist.~~electrologist or a laser clinician.**

(a) Any person who desires to be licensed as an "electrologist" pursuant to this Chapter shall:

(1) Submit an application on a form approved by the Board.
(2) Be a resident of North Carolina.
(3) Be ~~18~~ 21 years of age or older.
(4) Meet the requirements of subsection (a1) of this section.
(5) Pass an examination given by the Board.
(6) Submit the application and examination fees required in G.S. 88A-9(b).

(a1) An applicant for licensure under this section shall provide:
(1) Proof of graduation from a school certified by the Board pursuant to G.S. 88A-19; or
(2) Proof satisfactory to the Board that, for at least one year prior to the date of application or the date of initial residence in this State, whichever is earlier, the applicant was engaged in the practice of electrology in a state that does not license electrologists.

Subdivision (2) of this subsection applies only to applicants whose residence in this State began on or after January 31, 1994, who do not meet the qualifications of subdivision (1) of this subsection or G.S. 88A-12.

(b) At least twice each year, the Board shall give an examination to applicants for licensure to determine the applicants' knowledge of the basic and clinical sciences relating to the theory and practice of electrology. The Board shall give applicants notice of the date, time, and place of the examination at least 60 days in advance.

(c) When the Board determines that an applicant has met all the requirements for licensure, and has submitted the initial license fee required in G.S. 88A-9(b), the Board shall issue a license to the applicant.

(d) An applicant otherwise qualified for licensure who is not a resident of this State may nevertheless submit a statement of intent to begin practicing electrology in this State and receive a license. The applicant must provide to the Board within six months of receiving a license evidence satisfactory to the Board that the applicant has actually begun to practice electrology in this State. The Board may revoke the license of an applicant who fails to submit this proof or whose proof fails to satisfy the Board.

(e) A person seeking licensure by the Board as a laser clinician shall have met the following requirements at the time the license is requested:
(1) Be a licensed electrologist.
(2) Completed a 30-hour laser, light source, or pulsed-light treatment certification course approved by the Board and in accordance with rules adopted by the Board.
(3) Is currently using or anticipates using laser, light source, or pulsed-light devices that the person has been certified to operate."

SECTION 6. G.S. 88A-12 reads as rewritten:

"**§ 88A-12. License renewal.**

(a) Every electrologist license or laser clinician license issued pursuant to this Chapter must be renewed annually. On or before the date the current license expires, a person who desires to continue to practice electrology or as a laser clinician shall apply for license renewal to the Board on forms approved by the Board, provide evidence of

the successful completion of a long-term educational program approved by the Board, meet the criteria for renewal established by the Board, and pay the required fee. The Board may provide for the late renewal of licensure upon payment of a late fee as set by the Board, but late renewal may not be granted more than 90 days after expiration of the license.

(b) Any person who has failed to renew his or her license for more than 90 days after expiration may have it reinstated by applying to the Board for reinstatement on a form approved by the Board, furnishing a statement of the reason for failure to apply for renewal prior to the deadline, and paying the required fee. The Board may require evidence of competency to resume practice before reinstating the applicant's license."

SECTION 7. G.S. 88A-13 is amended by adding the following new subsection to read:

"(d) Laser clinicians are required to complete 10 hours of continuing education annually to maintain their licensure."

SECTION 8. Chapter 88A of the General Statutes is amended by adding the following new section to read:

"**§ 88A-17.1. Requirements for licensure as a laser clinician instructor.**

(a) Any person who desires licensure as a 'laser clinician instructor' pursuant to this Chapter shall meet the following requirements:

(1) Submit an application on a form approved by the Board.

(2) Be a licensed electrologist.

(3) Be a licensed electrology instructor.

(4) Have practiced laser and light-based treatments actively for at least one year immediately before the application.

(5) Have at least 100 hours of training in laser and light-based treatments.

(b) When the Board determines that an applicant has met all qualifications for certification as a laser clinician instructor and has submitted the required fee, the Board shall issue an instructor's license to the applicant."

SECTION 9. G.S. 88A-18 reads as rewritten:

"**§ 88A-18. Renewal of instructor's ~~certificate.~~license.**

An electrology or laser clinician instructor's ~~certificate~~ license shall be renewed annually. On or before the date the current ~~certificate~~ license expires, the applicant must submit an application for renewal of ~~certification~~ licensure on a form approved by the Board, meet criteria for renewal established by the Board, and pay the required fee. Any person whose instructor's ~~certificate~~ license has expired for a period of five years or more shall be required to take and pass the instructor's examination before the ~~certificate~~ license can be renewed."

SECTION 10. Chapter 88A of the General Statutes is amended by adding the following new section to read:

"**§ 88A-19.1. Requirements for certification as a Board-approved school of laser, light source, or pulsed-light treatments.**

(a) Any school in this State or another state that desires to be certified as a Board-approved school of laser, light source, or pulsed-light treatments shall:

(1) Submit an application on a form approved by the Board;

(2) Submit a detailed projected floor plan of the institutional area demonstrating adequate school facilities to accommodate students for purposes of lectures, classroom instruction, and practical demonstration;
(3) Submit a detailed list of the equipment to be used by the students in the practical course of their studies;
(4) Submit a copy of the planned laser, light source, or pulsed-light curriculum consisting of the number of hours and subject matter determined by the Board, provided that the number of hours required shall not be less than 30 hours and not more than 100 hours;
(5) Submit a certified copy of the school manual of instruction;
(6) Submit the names and qualifications of the licensed instructors; and
(7) Any additional information the Board may require.

(b) When the Board determines that an applicant has met all the qualifications for certification as a Board-approved school of laser, light source, or pulsed-light treatments and has submitted the required fee, the Board shall issue a certificate to the applicant.

(c) A school's certification is only valid for the location named in the application. When a school desires to change locations, an application shall be submitted to the Board on a form furnished by the Board, and the fee shall be paid for certificate renewal.

(d) A school's certification is not transferrable. Schools must immediately notify the Board in writing of any sale, transfer, or change in ownership or management.

(e) Every school shall display its certification in a manner prescribed by the Board.

(f) All laser, light source, or pulsed-light devices used in the school must be approved by the federal Food and Drug Administration."

SECTION 11. G.S. 88A-20 reads as rewritten:

"**§ 88A-20. Certification renewal.**

Every certificate issued pursuant to G.S. 88A-19 or G.S. 88A-19.1 shall be renewed annually. On or before the date the current certificate expires, the applicant must submit an application for renewal of certification on a form approved by the Board, meet criteria for renewal established by the Board, and pay the required fee. Failure to renew the certificate within 90 days after the expiration date shall result in automatic forfeiture of any certification issued pursuant to this Chapter."

SECTION 12. Section 2 of this act becomes effective December 1, 2005, and applies to offenses committed on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1330

Committee Substitute Favorable 8/23/05
Third Edition Engrossed 8/23/05
PROPOSED SENATE COMMITTEE SUBSTITUTE H1330-CSLU-12 [v.3]

5/9/2006 10:15:40 AM

Short Title: Authorize Licensure/Anesthesiologist Asst's. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA MEDICAL BOARD TO LICENSE AND REGULATE ANESTHESIOLOGIST ASSISTANTS.

Whereas, there is a documented shortage of anesthesia providers in North Carolina; and

Whereas, anesthesiologist assistants are licensed by many states to provide anesthesia services under the supervision of an anesthesiologist; and

Whereas, licensure of anesthesiologist assistants in North Carolina would help alleviate the existing shortage of anesthesia providers in this State; and

Whereas, anesthesiologist assistants have excellent clinical safety records, are highly trained, and are authorized to provide anesthesia services under such federal programs as Medicare, Medicaid, TriCare, and the Veterans Administration; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-11 is amended by adding a new subsection to read:

"(a1) Each applicant for licensure as an anesthesiologist assistant in the State shall satisfy the North Carolina Medical Board that the applicant is of good moral character and meets the other qualifications for the issuance of a license before a license is granted by the Board to the applicant."

SECTION 2. G.S. 90-15 reads as rewritten:

"**§ 90-15. License fee; salaries, fees, and expenses of Board.**

Each applicant for a license by examination shall pay to the North Carolina Medical Board a fee which shall be prescribed by the Board in an amount not exceeding the sum of four hundred dollars ($400.00) plus the cost of test materials before being admitted to the examination. Whenever a license is granted without examination, as authorized in G.S. 90-13, the applicant shall pay to the Board a fee in an amount to be prescribed by

the Board not in excess of two hundred fifty dollars ($250.00). Whenever a limited license is granted as provided in G.S. 90-12, the applicant shall pay to the Board a fee not to exceed one hundred fifty dollars ($150.00), except where a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training is granted, the applicant shall pay a fee of twenty-five dollars ($25.00), and where a limited license to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients is granted, the applicant shall not pay a fee. A fee of twenty-five dollars ($25.00) shall be paid for the issuance of a duplicate license. All fees shall be paid in advance to the North Carolina Medical Board, to be held in a fund for the use of the Board. The compensation and expenses of the members and officers of the Board and all expenses proper and necessary in the opinion of the Board to the discharge of its duties under and to enforce the laws regulating the practice of medicine or surgery shall be paid out of the fund, upon the warrant of the Board. The per diem compensation of Board members shall not exceed two hundred dollars ($200.00) per day per member for time spent in the performance and discharge of duties as a member. Any unexpended sum or sums of money remaining in the treasury of the Board at the expiration of the terms of office of the members of the Board shall be paid over to their successors in office.

For the initial and annual registration of an assistant to a physician, the Board may require the payment of a fee not to exceed a reasonable amount.

For the initial and annual registration of an anesthesiologist assistant, the Board may require the payment of a fee not to exceed one hundred fifty dollars ($150.00)."

SECTION 3. G.S. 90-18(c) is amended by adding a new subdivision to read:

"(c) The following shall not constitute practicing medicine or surgery as defined in subsection (b) of this section:

...

(20) The provision of anesthesia services by a licensed anesthesiologist assistant under the supervision of an anesthesiologist licensed under Article 1 of this Chapter."

SECTION 4. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.5. Limitations on anesthesiologist assistants.**

(a) Any person who is licensed under the provisions of G.S. 90-11 to perform medical acts, tasks, and functions as an assistant to an anesthesiologist licensed under Article 1 of this Chapter may use the title 'anesthesiologist assistant'. Any other person who uses the title in any form or holds himself or herself out to be an anesthesiologist assistant or to be so licensed shall be deemed to be in violation of this Article. A student in any anesthesiologist assistant training program shall be identified as a 'student anesthesiologist assistant' or an 'anesthesiologist assistant student', but under no circumstances shall the student use or permit to be used on the student's behalf, the terms 'intern', 'resident', or 'fellow'.

(b) Anesthesiologist assistants are authorized to provide anesthesia services under the supervision of an anesthesiologist licensed under Article 1 of this Chapter,

including the development and implementation of an anesthesia care plan for a patient, under the following conditions:

(1) The North Carolina Medical Board has adopted regulations governing the provision of anesthesia services by an anesthesiologist assistant under the supervision of an anesthesiologist licensed under Article 1 of this Chapter with such limitations as the Board may determine to be in the best interest of patient health and safety.

(2) The anesthesiologist assistant holds a current license issued by the Board.

(c) The North Carolina Medical Board shall adopt rules to implement this section."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 4

HOUSE BILL 1330

Committee Substitute Favorable 8/23/05
Third Edition Engrossed 8/23/05
Senate Health Care Committee Substitute Adopted 5/18/06

Short Title: Authorize Licensure/Anesthesiologist Asst's. (Public)

Sponsors:

Referred to:

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VISITOR REGISTRATION SHEET

Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pam Kilpatrick	OSBM
DAVID BARNES	Poyner + Spruill
Katherine Joyce	NCASA
Molly Ryan	NCSBA
Regina Acheampong	NCSBA
Pat Prudew	NCNA
Trent Praytor	NCNA
[illegible]	SA
Tom Vaughn	AIC
Bob Kelly	
Leanne Winner	NCSBA

W H Potter Jr NCPTA & NCDS

Don Vaughan D Honey

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Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
J Craig	UHS
Tim Boyum	News 14 Carolina
[illegible]	NCAHP
[illegible]	NCSA
[illegible]	~~AAAA~~
Amie L. Schilling	~~AAAA~~
David Johnson	AAAA
Grier Marshburn	~~AAAA~~
Sherief Eissa	~~AAAA~~
Ellen Allinger	AAAA
James Allinger	NCSA

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Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
M Hamrick	Electrolysis By Myrtle
Kelly Wade	AAAA
Thuan Ong	AAAA
Julian Grist	AAAA
DALILA WHITE	AAAA
SHANIAH JOHNSON	AAAA
BRITTANY PATTERSON	AAAA
ANTHONY MASSEY	AAAA
Kathy Stewart	American Academy of Anesthesiologist Assistants (AAAA)
Elona Stuben	AAAA

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Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Brooke Thompson	AAAA
Rebecca McGhee	Smith Anderson
Jessica A. Alexander, MD	NCSA
John B. Neeld, Jr. MD	Northside Hospital Atlanta, GA 30528
Thomas R Hill, MD.	NC Society of Anesthesiologists
Margaret O'Neal AAC	AAAA
Megan Varellas AA-C	AAAA
C A Macri MD	UCSF
Lauren Bronikowski	AAAA
Daphne Lyon	OSBM
Debbie Barnes	OSBM
Jeff Mixon	Civitas

VISITOR REGISTRATION SHEET

HEALTH CARE — **Name of Committee**

MAY 17, 06 — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Mike Carey	Citizens for Healthcare Freedom
Mark Allison	WFUBMC Nurse anesthesia program
DAVID ANDERSON	NC STATE OPTOMETRIC SOCIETY 204 IONA ST. FAIRMONT NC. 28340
HAL HERRING	NC STATE OPTOMETRIC SOCIETY
Chris Fitzsimon	NC Policy Watch
Eric Cerney	State Govt. Radio
Marcus Downs	N.C. State Health Plan
Mike Baker	AP
M Burger	N+R
Keith Richardson	Intern for Sen. Forrester
S Durham	Charlotte Observer

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Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Stevens	NCANA
Amy J Horne	NCNS
Jim Stegall	NC Legislative Services, U.C.P.S.
Christina Craig	WakeMed
Beth Marshall	NCANA
April Carter	Nurse Anesthetist
Amanda Auston	Nurse Anesthetist
Jim Nitz	Nurse Anesthetist
Crystal Wilson Charisse Balem	Parent Concord NC
Steve Eyler	optometrist Davidson NC
Barbara Canales	BSCOE
Stacy Flannery	NCHICFA
CARY Hodshon	SRNA, WFUBMC
Renea Shore	SRNA, WFUBMC

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Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Joseph Fisher	With Mom
Lois Fisher	Greater Piedmont Electrolysis Assoc.
Dorinda Stilwell	Pres. Greater Piedmont Electrolysis Assoc.
Trudy Brown	Greensboro NC (ALC)
Barbara Hurney	High Point NC (ALC) (Beaufort Co)
Lisa Hurlyn	Greater Piedmont Electrolysis Assoc.
Alice Santsing	Greater Piedmont Electrolysis Assoc. High Point
Dana Begley Combopiano	Raleigh Licensed Electrologist / Laser Therapist
Thelma Glenn White	Electrolysis ABC's of skincare Durham, NC. 27713
Thomas Mueller	NC ANA
Alex Johnson	NC ANA

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Senate Health Care Committee — May 17, 2006

Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Roger Bone	Bone + Assoc
Lou B. Wilson	NCAATC 7
Lu-Ann Coe	NCPA
Joyce Peters	NP Assoc
Clifford Gonzales	Wake Forest University BMC Nurse Anesthesia Programs
Suzanne Gregory	Wake Forest Univers. ty BMC Nurse Anesthesia Program
MARCIA GWINE	WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER NURSE ANESTHESIA PROGRAM
PATRICK BUFFKIN	ALLEY ASSOC INC
Frank Gray	NCANA
Ken Smith	Smith Anderson
Mike Lewis	NCSA

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HEALTH CARE — **Name of Committee**

MAY 17, 06 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julie Lowery, CRNA	NCANA / 198 Norwood Rd Chapel Hill 27516
Deborah L Marcinko CRNA	NCANA / 374 Woodhaven Dr. New Hill 27562
Linda Erskine-Bauer CRNA	NCANA / 201 Ashley Brook Ct, Cary NC 27513
Regina Wyatt	NCANA / 1307 Waverly Rd, Wilson NC 27893
Ann Dearing	Durham Public Schools
Peter J Morris	NC Pediatric Society
William O Young MD	NC Society of Eye Physicians + Surgeons
Nancy Shedlick, MSN, CRNA	NCANA / 204 Fulham Pl Raleigh NC 27615
Nancy Easton-Mann, CRNA, MS	NCANA / 7804 Hargis Mill Rd 27615
Linda Stone MSN, CRNA	NCANA / 1928 Wi Hon Circle 27615
Jones B. Darnell, MSN, CRNA	NCANA / 4531 Treerose Way Raleigh 27606

VISITOR REGISTRATION SHEET

HEALTH CARE — **Name of Committee**

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NAME	FIRM OR AGENCY AND ADDRESS
Sherry Owens, CRNA	NCANA
Jimmy Hicks CRNA	NCANA
Lynette Swan	HHS
Josh Mabry	GOV Affairs

VISITOR REGISTRATION SHEET

Senate Health Care Committee — May 17, 2006

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NAME	FIRM OR AGENCY AND ADDRESS
Melissa Jones	SRNA, WFUBMC
Kimberly Gordon	~~Student~~ nurse anesthetist (SRNA) WFUBMC
NIKKi Pitts	SRNA, Raleigh School of Nurse Anesthesia
Andrea Sain	SRNA, WFUBMC (NCANA)
Terri Wallace	SRNA, WFUBMC (NCANA)
Kristy Tyndall	CRNA, WFUBMC NCANA
Cally Higgins	Gov. office
Rob Alley	Alley Associates

Senate Health Care Committee
Wednesday, May 31, 2006, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 1276	CAP/DA Review and Report.	Senator Dannelly
SB 1277	NC NOVA-Special Voluntary Licensure Designat.	Senator Dannelly
SB 1278	Adult Day Awareness/Status of Study Recom.	Senator Dannelly
SB 1279	Review of NC Institutional Bias Report.	Senator Dannelly

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 31, 2006

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

FAVORABLE

S.B.	**1276**	CAP/DA Review and Report.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**1278**	Adult Day Awareness/Status of Study Recom.	
		Sequential Referral:	None
		Recommended Referral:	None

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 31, 2006

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

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

S.B. **1279** Review of NC Institutional Bias Report.

Draft Number:	PCS55482
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, May 31, 2006
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 31, 2006, in Room 544 of the Legislative Office Building, with fifteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Dannelly was recognized to present SB 1276, ***CAP/DA Review and Report***. Senator Dannelly stated the bill required the Department of Health and Human Services (DHHS) to review and report on the Community Alternatives Program for Disabled Adults (CAP/DA) program in response to the institutional bias report. This bill is a recommendation from the NC Study Commission on Aging. The report shall include actions taken and planned by the Department in response to each bias identified in the institutional bias study. The report shall include information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years. Also it should provide a description of the CAP/DA slot allocation formula, and a breakdown of slots by the county, including the reallocation of any unused slots. Additionally there shall be strategies to ensure the proper management of the CAP/DA waiting list and implementation of a uniform screening/assessment tool and other strategies to ensure CAP/DA services for those qualifying. The Department must give an interim report to the Aging Commission on or before August 30, 2006 and a final report on or before August 30, 2007. Senator Forrester asked if this refers to the use of the state's mental hospitals by Medicaid recipients and the bias being to certain counties that are having preference to putting patients in hospitals over other counties. Senator Dannelly replied that the bias deals with the fact that Medicaid makes it easier for patients to enter nursing homes as opposed to using Community Alternative Programs, which is In-Home Services, etc. Senator Forrester asked if there was any money involved in this study or was DHHS suppose to use their present budget. Shawn Parker, Research, stated the bill does not make an appropriation for the study; it is just a direction. Senator Forrester made the motion for a favorable report. The bill passed.

Senator Dannelly was recognized to present SB 1277, ***NC NOVA-Special Voluntary Licensure Designation.*** This bill establishes North Carolina New Organizational Vision Award, which is known as NC NOVA. This is a voluntary special licensure designation for home care agencies, nursing homes and adult care homes. This bill is a recommendation from the NC Study Commission on Aging. The bill indicates that those homes, which meet the strict onsite review and written response of this independent reviewing organization, will be rewarded a certification as opposed to being awarded a certificate. The bill also provides that the NOVA designation is not subject to administrative hearings under the administrative procedures act. This special licensure is

in addition to the operator's licensure used by the Division of Facilities Services in DHHS. Senator Dorsett asked if once they get the licensure, are they renewable or a one-time thing. Senator Dannelly replied it is renewable every two years. Senator Forrester asked if it establishes a new licensing board and also who re-licenses them. Ben Popkins, Research, stated it called for an additional designation to the licensure of the facility. Susan Harmuth, who is the project coordinator for NC NOVA and is with the North Carolina Foundation for Advanced Health Programs, stated the Division of Facility Services would still issue the special license. Senator Hartsell asked what is the Carolina Center for Medical Excellence. Susan Harmuth stated it was previously known as Medical Review of NC. When the program was initially developed it included all the trade associations, friends and residences of Long Term Care Consumer Advocates, direct care workers, and all the groups that are impacted by this legislation who have been involved with developing this program over the past three years. They wanted an outside independent review entity to actually go out to the locations and determine if they meet the special criteria so they would have equity and independence across the three settings of care. Sen. Hartsell also asked what the Carolina Center is. Peg O'Connell, Director of External Relations at the Carolina Center for Medical Excellence, stated they are the Medicare designated quality improvement organization for North and South Carolina and in that capacity they work with the designated providers of Medicare including the physicians, the hospitals, the nursing homes, and home health to improve the quality of care for the state's 1.3 million Medicare beneficiaries. They look at actual ways to improve the hands-on care in nursing homes and in-home health agencies. They work with staff to develop systems of care so that hands on workers deliver better care. They work with the Hospital Associations, helping them to do better care by doing data analysis to see where there might be gaps in delivering the best possible care. They have been designated as the quality improvement organization since 1983. Sen. Hartsell asked if they are private non-profit. Peg O'Connell answered they are a private not-for-profit corporation designated under federal law as physician-sponsored, which means a large number of their board members are Doctors. Senator Goodall asked if the program only rewards the providers or does any element regulate the care workers themselves. Senator Dannely responded it only regulates the company. Senator Goodall asked how it would reward the providers. Senator Dannelly stated getting the designation is the reward. Senator Goodall asked if the provider does not meet the qualification is there a penalty. Senator Dannelly stated there is no penalty - they just do not get the designation. Senator Jacumin asked who pays the review organization and how are they paid. Susan Harmuth stated there is a fee. NC NOVA has been developed under a Robert Wood Johnson and The Atlantic Philanthropies Grant. It is one of five grants awarded in the country to link policy and practice to impact retention of direct care workers because there is a tremendous shortage of this work force. The Grant funding is providing the payment for the review. The cost of the review is about $1,183.00, which is much less than accreditation and includes not only a desk review but includes an on site review. Senator Jacumin asked could this not be done when the licenses are issued. Stacey Flannery with the NC Health Care Facilities Association responded that they had a number of facilities that wanted to apply for this to address the Health Care Workforce Crisis. This is one

way to address the challenges of competing for and retaining health care workers. The facilities are recognized for putting in place the work force initiatives. Senator Dannelly stated he was surprised that the facilities would have to pay a fee, and it was not indicated in the bill. Staff said there were enough funds that the facilities would not have to pay a fee this year and if funds are not available next year they will address it in a bill. Susan Harmuth wanted to clarify that the grant pays the fee. Senator Kinnaird asked if she could ask Susan about the low pay of the workers, stating that if they have all the training and cannot make a living and go some place else it will be wasted. Susan Harmuth stated they need reward and recognition and a career ladder so they can get ahead. Senator Forrester stated the bill states that DHHS will establish the NOVA program and he asked does that cost the Department any funds or are they taking it out of their present budget. Jeff Horton with the Division of Facility Services (DHHS) stated they are the agency charged with licensing home care agencies, nursing homes, and adult care facilities. Mr. Horton stated the issuing of the special licensure designation would be absorbed in their current operations with no additional cost. Senator Nesbitt expressed concern on page 3 line 11; pointing out the bill states the Department shall implement the NC NOVA program in accordance with the criteria and protocols established by the Partner Team. Senator Nesbitt stated he had never seen it put in the statutes that the department was going to do whatever some outside agent tells them to do. Susan Harmuth stated they were trying to protect the work that had been done over the past three years. Senator Nesbitt also was concerned that all of this is exempt from the APA so as you write your rules the public does not need to be involved, and subsection (d) denial of a NC NOVA designation is not subject to Article 3 of 150B of the General Statutes, meaning the appeals process. Jeff Horton responded since this is voluntary and if the facility gets denied the department does not feel they should be defending it when it was a voluntary licensure. Senator Nesbitt asked what happened if someone was denied. Jeff Horton replied that they could reapply. Staff stated they could appoint a subcommittee, but Senator Dannelly did not want a subcommittee. Senator Dorsett moved for a favorable report. Senator Kinnaird asked about the subcommittee. Senator Bingham declared there are two more bills to be heard by the committee today and staff has indicated they would like to clarify some of the language, therefore Senate Bill 1277 will not be voted on today.

Senator Dannelly was recognized to present SB 1278, ***Adult Day Awareness/Status of Study Recom.***, which pertains to adult day and adult day health services in NC. It requires DHHS and the Division of Aging and Adult Services and the Division of Medical Assistance to provide education and training to Community Alternatives Program (CAP) case managers in order that they are aware of adult day health services and that these services are considered when appropriate. The status of the recommendations contained in the Partners in Caregiving Study is to be reported to the Study Commission on Aging by July 30, 2006. Senator Nesbitt stated the bill says they shall provide education and training and the question is are these people already in place and already funded. Dennis Streets, Director of the Division of Aging and Adult Services, stated they would rely on their existing staff to provide this education. Senator

Nesbitt moved for a favorable report. Senator Forrester asked if they could get done in 30 days. Dennis Streets indicated they were on schedule and could get it finished. Senator Kinnaird asked if they go there every single day to Day Health Service. Dennis Streets stated there is a nurse on site four hours per day and medications are administered and the amount of time spent there would be different for each case. Senator Nesbitt had already moved for a favorable report. The vote was taken and the bill passed.

Senator Dannelly presented SB 1279, ***Review of NC Institutional Bias Report.*** This bill directs DHHS to collaboration with providers and advocates of home and community-based services to make recommendations addressing biases identified in the Institutional Bias Report prepared by The Lewin Group. Senator Malone asked to send forth an amendment. Senator Malone explained the amendment on page 1 line 10; simply insert Long Term Care Services. Senator Malone made the motion to pass the amendment, which passed. Senator Bingham moved for a favorable report with the amendment rolled into a new Proposed Committee Substitute. The bill passed.

The meeting adjourned at 12:08 P.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1276*

Short Title:	CAP/DA Review and Report.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW THE CAP/DA PROGRAM IN RESPONSE TO ISSUES IDENTIFIED IN THE MEDICAID INSTITUTIONAL BIAS STUDY, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall examine the Community Alternatives Program for Disabled Adults (CAP/DA) in response to issues identified in the Medicaid Institutional Bias Study. The Department shall make an interim report of its findings to the North Carolina Study Commission on Aging on or before August 30, 2006, and shall submit its final report to the North Carolina Study Commission on Aging on or before August 30, 2007. The report shall include actions taken and planned by the Department in response to each bias identified in the study and shall include the following information:

(1) Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years.

(2) A description of the CAP/DA slot allocation formula; and a breakdown of slots by county, including the reallocation of any unused slots.

(3) Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists.

(4) Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This should

include information on whether the lists should be prioritized by risk of institutionalization.

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

SENATE BILL 1276:
CAP/DA Review and Report

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 19, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 1276 requires the Department of Health and Human Services to review the Community Alternatives Program for Disabled Adults (CAP/DA) in response to issues identified in the institutional bias study and to submit an interim and a final report. This bill is a recommendation from the NC Study Commission on Aging

HISTORY:

S.L. 2004-124, Section 10.13 required the Department of Health and Human Services to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias.

The Lewin Group conducted the study and identified 10 biases and recommendations, at least four of these relating to CAP/DA. On January 4, 2006 and March 29, 2006, the NC Study Commission on Aging heard presentations and discussed issues relating to the institutional bias report. In a letter dated March 29, 2006, Secretary Hooker Odom indicated that the Department was in the process of addressing a number of areas where additional work is needed.

BILL ANALYSIS:

Senate Bill 1276 requires the Department of Health and Human Services to review and report on the CAP/DA program in response to the institutional bias report. The report on CAP/DA shall include actions taken and planned by the Department in response to each bias identified in the institutional bias study. The inclusion of the following information is also required in the report:

(1) Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years.

(2) A description of the CAP/DA slot allocation formula; and a breakdown of slots by county, including the reallocation of any unused slots.

(3) Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists.

(4) Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This should include information on whether the lists should be prioritized by risk of institutionalization.

The Department must submit an interim report to the NC Study Commission on Aging on or before August 30, 2006, and a final report on or before August 30, 2007. The act is effective when it becomes law.

ADDITIONAL INFORMATION:

A May 6-7, 2006 article in *The Wall Street Journal* contained information on a shift from institutional to home and community care for the elderly. The article mentions a University of California-San Francisco study that concluded that an average of $15,000 a year in Medicaid savings could be obtained for each person who received

care at home, instead of a nursing home. The article also mentions a Congressional Budget Office analysis in 2004 that found that 77% of Medicaid spending went to institutions while 23% went to supporting the elderly in their homes. Home and community care is not the best alternative for everyone and the appropriate location for care depends on many factors. However, the WSJ article quotes Mark McClellan, Administrator of the Centers of Medicare & Medicaid Services as saying, "We have a system that was developed 40 years ago and that we need to reform," "We have to have payments in Medicare and Medicaid that move away from supporting institutions to supporting individuals."

Theresa Matula substantially contributed to this summary.

S1276e1-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1277*

Short Title:	NC NOVA-Special Voluntary Licensure Designat.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA NEW ORGANIZATIONAL VISION AWARD SPECIAL LICENSURE DESIGNATION, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

Whereas, "direct care workers" is a nationally recognized term referring to those paraprofessionals that are employed as nurse aides, personal care aides, personal care attendants, home health aides, in-home aides, habilitation aides, and other assistive personnel who provide hands-on care; and

Whereas, direct care workers are essential to the provision of care and an enhanced quality of life for long-term care consumers, whether they are receiving services provided in a home or community setting, or in a residential or institutional setting; and

Whereas, North Carolina, like many states, is experiencing shortages of direct care workers; and

Whereas, the need to attract and retain greater numbers of employees within this occupational category will continue for the foreseeable future; and

Whereas, a well-qualified, satisfied, stable, and adequate supply of direct care workers is a shared concern for employers, employees, consumers, families, and private and public payors of long-term care services received in home care agencies, adult care homes, and nursing facilities; and

Whereas, long-term care trade associations, providers, direct care workers, consumer advocacy organizations, researchers, the Department of Health and Human Services, and The Carolinas Center for Medical Excellence have worked together to develop a voluntary and comprehensive workplace culture change program known as the North Carolina New Organizational Vision Award (NC NOVA) to address known causes of direct care turnover for the purpose of improving the adequacy, stability, satisfaction, and quality of the direct care work; and

Whereas, NC NOVA has been identified as a potential national model for replication to improve direct care workforce retention through a comprehensive and voluntary workplace culture program by the Institute for the Future of Aging Services, the program office for the national Better Jobs Better Care initiative funded by the Robert Wood Johnson Foundation, and The Atlantic Philanthropies; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 6. North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation.

"**§ 131E-154.12. Title; purpose.**

(a) This Part shall be known as the "North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation."

(b) The purpose of this Part is to establish special licensure designation requirements for nursing homes and home care agencies licensed pursuant to this Chapter and adult care homes licensed pursuant to Article 1 of Chapter 131D. Application for the Special Licensure Designation is voluntary.

"**§ 131E-154.13. Definitions.**

The following definitions apply in this Part, unless otherwise specified:

(1) Independent Review Organization. – The organization responsible for the application, review, and determination process for NC NOVA designation.

(2) North Carolina New Organizational Vision Award (NC NOVA). – A special licensure designation for home care agencies and nursing homes licensed pursuant to this chapter, and adult care homes licensed pursuant to Article 1 of Chapter 131D, that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents.

(3) NC NOVA Partner Team. – The entity responsible for developing the criteria and protocols for the NC NOVA special licensure designation. The Partner Team is inclusive of representatives from the following organizations: Association for Home and Hospice Care of North Carolina, Direct Care Workers Association of North Carolina, Duke University Gerontological Nursing Program, Friends of Residents in Long Term Care, North Carolina Assisted Living Association, North Carolina Association of Long Term Care Facilities, North Carolina Association of Non-Profit Homes for the Aging, North Carolina Department of Health and Human Services, North Carolina Foundation for Advanced Health Programs, North Carolina Health Care Facilities Association, The Carolinas Center for Medical

Excellence, and the University of North Carolina at Chapel Hill – Institute on Aging.

(4) NC NOVA Provider Information Manual. – The document developed by the NC NOVA Partner Team that specifies the scope of criteria for NC NOVA designation as well as information and procedures pertaining to the application, review, determination, and termination process.

"**§ 131E-154.14. NC NOVA Program established.**

(a) The Department of Health and Human Services shall establish the NC NOVA program.

(b) The Department shall implement the NC NOVA program in accordance with the criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(c) Any information submitted by applicants or obtained by the independent review organization related to NC NOVA, as well as annual turnover data voluntarily submitted by home care agencies, adult care homes, and nursing facilities for the purposes of assessing statewide turnover trends, shall not be considered a public record under G.S. 132-1.

(d) Denial of a NC NOVA designation is not subject to Article 3 of Chapter 150B of the General Statutes.

(e) Any licensed home care agency, adult care home, or nursing home that is determined not to have met the criteria for NC NOVA designation may reapply at intervals specified by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(f) The Department of Health and Human Services, Division of Facility Services, shall issue a NC NOVA special licensure designation document to any licensed home care agency, adult care home, or nursing home that is determined by the independent review organization to have met the criteria for NC NOVA designation. The special licensure designation document shall be in addition to the operating license issued by the Division.

(g) The Division of Facility Services shall issue the NC NOVA special licensure document to successful applicants within 30 days of notification by the independent review organization.

(h) The NC NOVA special licensure designation shall be in effect for a two-year period unless the provider has a change in ownership.

(1) Upon a change in ownership, if the new owner wishes to continue the NC NOVA designation, the new owner must communicate the desire in writing to the independent review organization within 30 days of the effective date of the change of ownership and proceed with an expedited review in accordance with procedures detailed by the NC NOVA Partner Team and included in the NC NOVA Provider Information Manual.

a. If the new owner continues to meet the NC NOVA criteria, based upon the expedited review, the special licensure

designation will remain in effect for the remainder of the two-year period.

b. If the new owner fails to meet NC NOVA criteria, the special designation document shall be immediately returned to the Division of Facility Services. The new owner may reapply for NC NOVA designation under subsection (e) of this section.

(2) Within 30 days of the effective date of the change of ownership, if the new owner fails to notify the independent review organization in writing of the desire to retain the special licensure designation by undergoing an expedited review, the designation will become null and void, and the special designation document must be immediately returned to the Division of Facility Services."

SECTION 2.(a) In order to ensure continuity during the initial statewide implementation phase of NC NOVA, The Carolinas Center for Medical Excellence shall be designated as the independent review organization for NC NOVA through December 31, 2010. Beginning in 2009, the Division of Facility Services, with approval from the NC NOVA Partner Team, shall implement a competitive bid process to determine an independent review organization for a minimum of five years beginning in 2011.

SECTION 2.(b) During the period of the effective date of this act, through December 31, 2010, in the event The Carolinas Center for Medical Excellence determines it cannot continue conducting independent reviews, The Carolinas Center for Medical Excellence shall provide the Partner Team with a 12-month written notice of such intent, in order to ensure sufficient transition time to select another independent review entity without any disruption of the NC NOVA program.

SECTION 3. This act becomes effective January 1, 2007.

SENATE BILL 1277:
NC NOVA-Special Voluntary Licensure Designat

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 19, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 1277 establishes the North Carolina New Organizational Vision Award (NC NOVA) which is a voluntary special licensure designation for home care agencies, nursing homes and adult care homes. This bill is a recommendation from the NC Study Commission on Aging and is supported by the House Select Committee on Health Care.

BILL ANALYSIS:

SB 1277 adds a new Part to Article 5 of Chapter 131E establishing the North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation. The NC NOVA licensure designation will be rewarded to nursing homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents.

NC NOVA Program - Under G.S. 131E-154.14, the NC NOVA program will be implemented by the Department of Health and Human Services (DHHS) in accordance with criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual. G.S. 131E-154.13 contains definitions of the Provider Information Manual and the Partner Team, including an extensive list of those organizations represented on the Partner Team. The bill specifies that information submitted by applicants, obtained by the independent review organization, including turnover data, is not considered a public record under G.S. 132-1. Additionally, the bill provides that denial of NC NOVA designation is not subject to administrative hearings under the Administrative Procedure Act.

Licensure Designation – The special licensure designation is in addition to the operating license issued by the Division of Facility Services, DHHS. The Division will issue the NC NOVA licensure document to successful applicants within 30 days of notification and the designation is awarded for a two-year period unless there is a change in ownership. G.S. 131E-154.14(h) contains information on the NC NOVA process when a change in ownership occurs.

Independent Review Organization - The independent review organization is defined in the definitions section on page 2, lines 20-22. On page 4, Section 2 of the bill provides that The Carolinas Center for Medical Excellence will be designated as the independent review organization through December 31, 2010. (Section 2(b) contains the procedure if The Carolinas Center can no longer function in this capacity.) Section 2(a) provides for a bid process to determine an independent review organization for a minimum of five years beginning in 2011.

The effective date of the bill is January 1, 2007.

BACKGROUND:

NC NOVA is a voluntary special licensing award for home care agencies, adult care homes, and nursing homes. The project has been funded thus far by The Robert Wood Johnson Foundation and The Atlantic Philanthropies, with the Institute of the Future of Aging Services in Washington serving as the national

program office. Currently, NC NOVA is being piloted in 60 sites: 20 adult care homes, 20 nursing homes, and 20 home health agencies. The pilot phase lasted from July 2005 until May 2006.

The NC NOVA project focuses on direct care workers, a category which includes nurse aides, in-home aides/home health aides, and personal care aides/attendants. It is an incentive/reward based program with uniform criteria across long-term care settings. Review will be conducted by the Carolinas Center for Medical Excellence and a special license is issued for entities obtaining the NC NOVA designation.

North Carolina has high turnover rates for direct care workers, with average annual rates in 2004 as follows: 106% in adult care homes, 107% in nursing homes, and 41% in home care agencies. Additionally, direct care jobs are among the occupations with the largest projected job growth - it is anticipated that NC will need 30,590 additional direct care workers from 2002 to 2012.

NC NOVA has a training component as one of the four major domains. The program also includes pieces that assist direct care workers in efforts to address work/personal related barriers to success, and NC NOVA contains a peer mentor program. The training component includes criteria regarding development of a training plan, focus on person centered services, linkages with quality improvement initiatives and incorporating topics generated with input from direct care workers, use of adult education teaching principles, looking at low and high volume tasks that have associated risk, as well as other elements. The NC NOVA program also includes a management support element that includes offering case management or employee counseling to address logistical and emotional issues such as coordinating access to community services needed to overcome obstacles such as childcare, transportation, and housing. Additionally, management offers support groups for employees to address life/work issues, especially in the first 90 days of employment.

NC NOVA does need legislation, but State funds are not needed as the grant contains sufficient funds for operation in FY 2006-2007. The goal of the special licensure designation is to improve recruitment, retention, development, and job satisfaction of the direct care workforce; and improve the care provided to long-term care clients, residents, and patients. It is anticipated that NC NOVA will benefit providers, workers and consumers.

RECENT STUDIES ON DIRECT CARE STAFF

A February 2006 study prepared by the University of California, San Francisco contains information on direct care workers and factors affecting the projected need. Findings in the report include the following:

> "The demand for professionals (physicians, nurses, physical therapists, etc.) needed to care for the future aging population will be dwarfed by the vast number of non-licensed formal and informal caregivers need[ed] to care for the elderly in home and community settings."
>
> "Assuring the quality of care in nursing homes will continue to be a concern among policymakers and consumers."
>
> "Regardless of limitations of forecasting models, most experts agree that there will be an increasing demand for long-term care services, merely due the increasing numbers of the elderly in our population."

Additionally, three studies were recently released by Better Jobs Better Care initiative, funded by The Robert Wood Johnson Foundation and The Atlantic Philanthropies, http://www.bjbc.org/. These studies showed that, "Targeted training, accessible and hands-on continuing education and designated staff retention specialists can help increase direct care worker retention and help providers improve the quality of long-term care for the elderly and disabled persons."

Theresa Matula substantially contributed to this summary.

S1277e1-SMRD

NC NOVA:

NORTH CAROLINA'S

NEW ORGANIZATIONAL VISION AWARD

North Carolina New Organizational Vision Award

How NC NOVA Works

- The provider takes extra steps in the hope of earning NC NOVA designation.
- The Carolinas Center for Medical Excellence conducts an independent review to determine whether the provider meets the comprehensive NC NOVA standards.
- The N.C. Division of Facilities Services issues the special NC NOVA license as recommended by The Carolinas Center for Medical Excellence.

What will NC NOVA do?

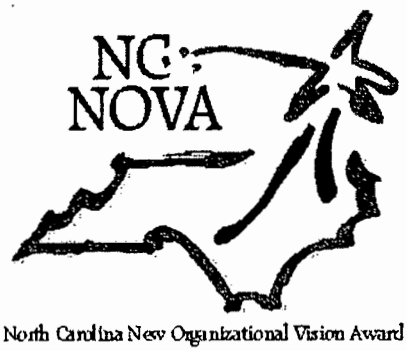
- NC NOVA will change the workplace culture across settings of long-term care.
- NC NOVA will show how long-term care management and direct care workers can be more supportive of each other.
- NC NOVA will create ways of improving the long-term care for consumers.

Why will NC NOVA succeed?

- All of the statewide long-term care provider associations support NC NOVA.
- Consumers will search out providers who have earned NC NOVA designation.
- NC NOVA providers will improve the retention of their direct care workers.

Why should the state support NC NOVA?

- NC NOVA will help long-term care providers meet the growing demand for direct-care workers.
- NC NOVA will improve quality and consumer confidence in long-term care.
- NC NOVA will create a way to measure the impact of workplace culture on quality of care.



North Carolina New Organizational Vision Award

What is NC NOVA

- NC NOVA is a special state license awarded to home care agencies, adult care homes and nursing facilities that is over and above their operating license.
- NC NOVA is a voluntary program to reward providers who meet a comprehensive set of rigorous, higher standards to support their direct care workers on the job.
- NC NOVA is the first program of its kind in the United States.

Why have NC NOVA

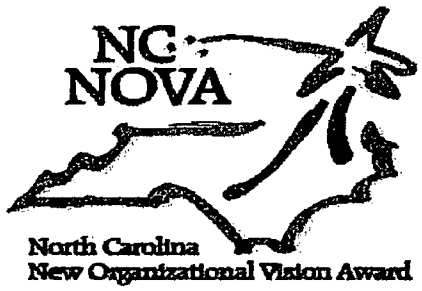
- NC NOVA will help long-term care employers find and keep quality direct care workers to meet current and future demand.
- NC NOVA will improve the long-term care family members and their loved ones receive.
- NC NOVA will make direct care jobs more attractive and satisfying career options.

How NC NOVA is different

- NC NOVA is a voluntary program with uniform, written guidelines for raising the bar across all settings for long-term care.
- NC NOVA brings all the major stakeholders to the same table.
- NC NOVA builds on the relationship between job satisfaction and quality care.

Who created NC NOVA

- Providers, consumers, workers, regulators and educators jointly developed the guidelines for NC NOVA.
- The state's major long-term care provider associations recommended 60 of their members to pilot test NC NOVA.
- The Robert Wood Johnson Foundation and The Atlantic Philanthropies funded a $1.2 million grant for the state to create NC NOVA.



NC NOVA PARTNER TEAM

Association for Home and Hospice Care of North Carolina

North Carolina Assisted Living Association

North Carolina Association, Long-Term Care Facilities

North Carolina Association Non-Profit Homes for the Aging

North Carolina Health Care Facilities Association

Harnett Manor: Direct Care Supervisor representative
Direct Care Worker representative

Direct Care Workers Association of North Carolina

North Carolina Friends of Residents in Long-Term Care

Individual Consumer Representative

North Carolina Institute on Aging, UNC-Chapel Hill

Gerontological Nursing Specialty Program, Duke University

The Carolinas Center for Medical Excellence
(previously Medical Review of North Carolina)

North Carolina Department of Health and Human Services

North Carolina Foundation for Advanced Health Programs

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1278*

Short Title:	Adult Day Awareness/Status of Study Recom.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ENSURE AWARENESS OF ADULT DAY HEALTH SERVICES AND TO PROVIDE A STATUS REPORT ON CHANGES IMPLEMENTED AS A RESULT OF THE ADULT DAY SERVICES STUDY, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Aging and Adult Services and the Division of Medical Assistance, shall provide education, and training if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services and that this option is being considered in all situations appropriate for the client.

SECTION 1.(b) The Department of Health and Human Services, Division of Aging and Adult Services, shall report on the status of the Partners in Caregiving Study recommendations.

SECTION 1.(c) The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging not later than July 30, 2006.

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

SENATE BILL 1278:
Adult Day Awareness/Status of Study Recom

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 19, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 1278 directs the Department of Health and Human Services to ensure that CAP case managers are aware of adult day health programs, and it requires the Department to make a status report on the Partners in Caregiving study recommendations by July 30, 2006. This bill is a recommendation by the NC Study Commission on Aging.

BILL ANALYSIS:

Senate Bill 1278 pertains to adult day and adult day health services in North Carolina. The bill requires the following:

- The Department of Health and Human Services, Division of Aging and Adult Services and the Division of Medical Assistance, must provide education, and training if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services and that this option is being considered in all situations appropriate for the client.
- The Department's Division of Aging and Adult Services must report on the status of recommendations contained in the Partners in Caregiving Study.

With regard to the two activities above, the Department is required to report to the Study Commission on Aging by July 30, 2006. The act is effective when it becomes law.

BACKGROUND:

The Study Commission on Aging report to the 2006 General Assembly contained a recommendation for this bill. **Section 1(a) of the bill**, pertaining to increased awareness of adult day health services, is in response to a presentation on health services provided to Community Alternatives Program (CAP) participants as compared to health services provided at an adult day health care program. The Commission realizes that adult day health services may not be appropriate for all CAP clients, but believes that some clients may benefit from the health services and routine monitoring provided in an adult day health facility. Adult day health care may also be a more cost effective option for some clients. This provision will simply increase the awareness of adult day health facilities among CAP case managers. **Section 1(b) of the bill**, pertaining to the status of the adult day care study, is in response to a presentation on the adult day services study by Partners in Caregiving, authorized by S.L. 2004-124, Sec. 10.21. The Division of Aging and Adult Services has begun work on some of the recommendations contained in the study report. This bill will allow the Commission to continue to track the status of adult day and adult day health programs and to monitor progress on the study recommendations.

Adult Day programs serve adults with decreased physical, mental and social functioning. Clients attend the program during the day and return home in the evening. There are three program models: a social model, a health model, and a combination of the two. Program services include: mental and physical exercises and stimulation, meals, and opportunities for social interaction. The health models assist with medication management and the provision of personal care services, and have a nurse onsite for a minimum of four hours per day.

North Carolina currently has 49 adult day care programs with the social model, 54 combination programs and 3 adult day health only programs, for a total of 106 adult day care programs in 57 counties. The average cost for providing services in an adult day care facility is $46.00 per day, the average cost for providing services in an adult day health care facility is $53.00 per day.

Theresa Matula substantially contributed to this summary.

S1278e1-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1279*

Short Title:	Review of NC Institutional Bias Report.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO COLLABORATE WITH PROVIDERS AND ADVOCATES OF HOME AND COMMUNITY-BASED SERVICES TO REVIEW AND MAKE RECOMMENDATIONS ADDRESSING BIASES IDENTIFIED IN THE NORTH CAROLINA INSTITUTIONAL BIAS STUDY REPORT, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall collaborate with providers and advocates of home and community-based services to review the North Carolina Institutional Bias Study Report prepared by the Lewin Group and make recommendations on ways to address the biases identified in the report. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging on or before October 15, 2006.

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

SENATE BILL 1279:
Review of NC Institutional Bias Report

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 19, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 1279 requires collaboration between the Department of Health and Human Services and providers and advocates of home and community-based services to review and make recommendations addressing biases identified in the Institutional Bias Study Report. This bill is a recommendation from the North Carolina Study Commission on Aging.

HISTORY:

The NC Study Commission on Aging recommended that the 2004 General Assembly require the Department of Health and Human Services to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and to recommend ways to alleviate this bias, if such a bias exists. (Recommendation 8 in the report.) S.L. 2004-124, Section 10.13 required the Department of Health and Human Services to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias.

The Lewin Group conducted the study and identified 10 biases and recommendations. The Study Commission on Aging received information and engaged in discussion about the report during meetings on January 4, 2006 and March 29, 2006. In a letter dated March 29, 2006, Secretary Hooker Odom indicated that the Department was in the process of addressing a number of areas where additional work is needed.

BILL ANALYSIS:

Senate Bill 1279 directs the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to make recommendations addressing the biases identified in the institutional bias report prepared by The Lewin Group. (Institutional bias refers to the policies and practices within Medicaid that make it easier for a beneficiary to access institutional care than services in home and community based settings.)

The Department is required to report its findings and recommendations to the NC Study Commission on Aging on or before October 15, 2006. The act would be effective when it becomes law.

ADDITIONAL INFORMATION:

The May 6-7, 2006 edition of *The Wall Street Journal* contained a front page article on a shift from institutional to home and community care for the elderly. The article mentions a University of California-San Francisco study that concluded that an average of $15,000 a year in Medicaid savings could be obtained for each person who received care at home, instead of a nursing home. The article also mentions a Congressional Budget Office analysis in 2004 that found that 77% of Medicaid spending went to institutions while 23% went to supporting the elderly in their homes. Home and community care is not the best alternative for everyone and the appropriate location for care depends on many factors. However, the WSJ article quotes Mark McClellan, Administrator of the Centers of Medicare & Medicaid Services as saying, "We have a system that was developed 40 years ago and that we need to reform," "We have to have payments in Medicare and Medicaid that move away from supporting institutions to supporting individuals."

Theresa Matula substantially contributed to this summary.

S1279e1-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1279*
PROPOSED COMMITTEE SUBSTITUTE S1279-PCS55482-RD-42

Short Title: Review of NC Institutional Bias Report. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO COLLABORATE WITH PROVIDERS AND ADVOCATES OF HOME AND COMMUNITY-BASED SERVICES TO REVIEW AND MAKE RECOMMENDATIONS ADDRESSING BIASES IDENTIFIED IN THE NORTH CAROLINA INSTITUTIONAL BIAS STUDY REPORT, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall collaborate with providers and advocates of home and community-based long-term care services to review the North Carolina Institutional Bias Study Report prepared by the Lewin Group and make recommendations on ways to address the biases identified in the report. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging on or before October 15, 2006.

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

VISITOR REGISTRATION SHEET

Health and Human Resources
Name of Committee **Date May 31, 2006**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marion Suite	NCSO/NCSA/Glaxo
Elizabeth Dalton	NCRMA
Hailey Taylor	NCHA

VISITOR REGISTRATION SHEET

Health and Human Resources
Name of Committee **Date May 31, 2006**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Jessica Hubbard	East Carolina University
BRIAN SHANK	ASTRAZENECA
Lee Hodge	KCH
John Bowdish	AstraZeneca
Roger Bone	Bone & Assoc
Bill Rustin	ACP
Dennis Streets	NC Div of Aging & Adult Service, DHHS
Mary Edwards	NC DAAS, DHHS
Shannon Crane	Same as above
Ken Mossbrucker	Payson & Associates
Anne White	DAAS-

VISITOR REGISTRATION SHEET

Health and Human Resources
Name of Committee **Date May 31, 2006**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Peg O'Connell	CCME
Susan Hamworth	NC NOVA
Hugh Tilson	NCHA
J Craig Lewis	UHS
Michelle Frazier	NC Bar Ass'n
	NCMS
Adam S. Keith	NCGA
Nancy Lopez	LPGA
Ken Wright	NCSA

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Health and Human Resources
Name of Committee **Date May 31, 2006**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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WP Pulley	NCATL
B Wilson	AARP
Kellie Visker	AARP
Jacquie Halladay	UNC Chapel Hill Preventive medicine
Suzanne Lazorick MD, MPH	"
David Barnes	Poyner Spruill
Kristin Kelly	Gov. office
Lynne Perrin	DHHS-DMA
My sister	AARP-NC
Kathleen Edwards	UNC-CH Daily Bulletin
Lynette Jones	HHS
Evelyn Hamilton	DHHS

VISITOR REGISTRATION SHEET

Health and Human Resources
Name of Committee **Date May 31, 2006**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Dana Simpson	Smith Anderson
Christine Cruz	WakeMed
Karen Johnson	Smith Anderson
[illegible]	Bar Assn
Stacy Flannery	NCAHCPA
Barbara Conklin	BSC&R
Patrick Baffkin	ALLEY ASSOC, INC.
Cully Wiggins	GOVOFFICE
John McMillan	GOVOFFICE
Jerry Cooper	NCACA
Gail Rhodes	NC Nurses Association

VISITOR REGISTRATION SHEET

Health and Human Resources
Name of Committee **Date May 31, 2006**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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GARY KUEBER, MD, MPH	UNC PREVENTIVE MEDICINE
Holly Biola, MD MPH	UNC Preventive Medicine
Nathan Almond, MD	UNC Preventive Medicine
Molly Berkoff MD, MPH	"
Annette DuBard MD MPH	"
Deborah Parkerfield MD MPH	"
PATRICK HANNAH, JD	DURHAM CHAMBER OF COMMERCE
Abby C. Emanuelson	Nat'l MS Society
Lynn A. Burke	NC SHP
William Potter	NC Dental Society & NC PHEIS ASS'N.
Jim Edgerton	AHEC

AGENDA

SENATE HEALTH CARE COMMITTEE
June 7, 2006, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bills to be Considered

- SB1277 NC NOVA-Special Voluntary Licensure Designat. Sen. Dannelly
- SB1274 LTC Fines Posted on Internet. Sen. Dannelly
- SB1275 Health Care Personnel Registry Expansion Sen. Dannelly
- SB1280 DHHS Evaluate Telemonitoring Sen. Dannelly

IV Other Business

V. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, June 08, 2006

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

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

S.B. **1277** NC NOVA-Special Voluntary Licensure Designat.

Draft Number:	PCS55490-SQ-59
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday June 7, 2006
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 7, 2006, in Room 544 of the Legislative Office Building, with thirteen members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell told the committee that SB 1274, *LTC Fines Posted on Internet* and SB 1280, *DHHS Evaluate Telemonitoring,* are removed for consideration from today's calendar.

He recognized Senator Dannelly to present SB 1277, *NC NOVA-Special Voluntary Licensure Designat.* Senator Nesbitt proposed an amendment. Senator Dannelly moved to adopt that amendment and roll it into a Proposed Committee Substitute. The motion passed unanimously. Senator Jacumin asked if this bill would result in another level of bureaucracy, and Senator Dannelly replied that this is a totally voluntary licensure designation, that facilities could apply for this designation, and there is no penalty for not applying for this designation. Senator Nesbitt pointed out that the biggest problem in the field is staffing, and that this designation would help keep qualified people in the designated facilities by recognizing the personnel and some of the conditions under which they have to work. Senator Forrester asked how the program would be funded when the grant runs out, and Senator Dannelly responded that he did not know. Senator Kinnaird pointed out that the facility personnel make very little money, and Senator Dannelly said that this program would not affect wages. Senator Dorsett moved for a favorable report and the bill passed as amended.

Senator Dannelly presented SB 1275, *Health Care Personnel Registry Expansion,* which expands the definition of health care facility and health care personnel and contains an appropriation for expanding staff. Regarding staff personnel accused of wrongdoing, Senator Forrester raised the question as to whether this should be noted on the Registry until the matter is investigated and the individual found guilty. Mr. Jesse Goodman, Chief of the Health Care Personnel Registry Section, stated that once an allegation has been made, it is required to be noted on the Registry. When the allegation is reviewed, if found to be unsubstantiated, the notation is removed. When the allegation has been investigated and substantiated, and has gone through the appeals process, it becomes a permanent part of that individual's record. Mr. Goodman pointed out that under current law passed in 1996, facilities are required to check the Registry when hiring. Senator Dannelly expressed concern that a person's name appear on the Registry before a charge is substantiated, and he asked that the bill be pulled from consideration at this time.

The meeting adjourned at 11:53 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 2005

S 2

SENATE BILL 1277*

Health Care Committee Substitute Adopted 6/8/06

Short Title: NC NOVA-Special Voluntary Licensure Designat. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA NEW ORGANIZATIONAL VISION AWARD SPECIAL LICENSURE DESIGNATION, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

Whereas, "direct care workers" is a nationally recognized term referring to those paraprofessionals that are employed as nurse aides, personal care aides, personal care attendants, home health aides, in-home aides, habilitation aides, and other assistive personnel who provide hands-on care; and

Whereas, direct care workers are essential to the provision of care and an enhanced quality of life for long-term care consumers, whether they are receiving services provided in a home or community setting, or in a residential or institutional setting; and

Whereas, North Carolina, like many states, is experiencing shortages of direct care workers; and

Whereas, the need to attract and retain greater numbers of employees within this occupational category will continue for the foreseeable future; and

Whereas, a well-qualified, satisfied, stable, and adequate supply of direct care workers is a shared concern for employers, employees, consumers, families, and private and public payors of long-term care services received in home care agencies, adult care homes, and nursing facilities; and

Whereas, long-term care trade associations, providers, direct care workers, consumer advocacy organizations, researchers, the Department of Health and Human Services, and The Carolinas Center for Medical Excellence have worked together to develop a voluntary and comprehensive workplace culture change program known as the North Carolina New Organizational Vision Award (NC NOVA) to address known causes of direct care turnover for the purpose of improving the adequacy, stability, satisfaction, and quality of the direct care work; and

Whereas, NC NOVA has been identified as a potential national model for replication to improve direct care workforce retention through a comprehensive and

voluntary workplace culture program by the Institute for the Future of Aging Services, the program office for the national Better Jobs Better Care initiative funded by the Robert Wood Johnson Foundation, and The Atlantic Philanthropies; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 6. North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation.

"**§ 131E-154.12. Title; purpose.**

(a) This Part shall be known as the "North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation."

(b) The purpose of this Part is to establish special licensure designation requirements for nursing homes and home care agencies licensed pursuant to this Chapter and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes. Application for the Special Licensure Designation is voluntary.

"**§ 131E-154.13. Definitions.**

The following definitions apply in this Part, unless otherwise specified:

(1) Independent Review Organization. – The organization responsible for the application, review, and determination process for NC NOVA designation.

(2) North Carolina New Organizational Vision Award (NC NOVA). – A special licensure designation for home care agencies and nursing homes licensed pursuant to this Chapter, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes, that have been determined through written and on-site review by an independent review organization to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff and the care provided to long-term care clients and residents.

(3) NC NOVA Partner Team. – The entity responsible for developing the criteria and protocols for the NC NOVA special licensure designation. The Partner Team is inclusive of representatives from the following organizations: Association for Home and Hospice Care of North Carolina, Direct Care Workers Association of North Carolina, Duke University Gerontological Nursing Program, Friends of Residents in Long Term Care, North Carolina Assisted Living Association, North Carolina Association of Long Term Care Facilities, North Carolina Association of Non-Profit Homes for the Aging, North Carolina Department of Health and Human Services, North Carolina Foundation for Advanced Health Programs, North Carolina Health Care Facilities Association, The Carolinas Center for Medical Excellence, and the University of North Carolina at Chapel Hill – Institute on Aging.

(4) NC NOVA Provider Information Manual. – The document developed by the NC NOVA Partner Team that specifies the scope of criteria for NC NOVA designation as well as information and procedures pertaining to the application, review, determination, and termination process.

"**§ 131E-154.14. NC NOVA program established.**

(a) The Department of Health and Human Services shall establish the NC NOVA program.

(b) The Department shall adopt rules to implement the NC NOVA program in accordance with the criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(c) Any information submitted by applicants or obtained by the independent review organization related to NC NOVA, as well as annual turnover data voluntarily submitted by home care agencies, adult care homes, and nursing facilities for the purposes of assessing statewide turnover trends, shall not be considered a public record under G.S. 132-1.

(d) Any licensed home care agency, adult care home, or nursing home that is determined not to have met the criteria for NC NOVA designation may reapply at intervals specified by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(e) The Department of Health and Human Services, Division of Facility Services, shall issue a NC NOVA special licensure designation document to any licensed home care agency, adult care home, or nursing home that is determined by the independent review organization to have met the criteria for NC NOVA designation. The special licensure designation document shall be in addition to the operating license issued by the Division.

(f) The Division of Facility Services shall issue the NC NOVA special licensure document to successful applicants within 30 days of notification by the independent review organization.

(g) The NC NOVA special licensure designation shall be in effect for a two-year period unless the provider has a change in ownership.

(1) Upon a change in ownership, if the new owner wishes to continue the NC NOVA designation, the new owner must communicate the desire in writing to the independent review organization within 30 days of the effective date of the change of ownership and proceed with an expedited review in accordance with procedures detailed by the NC NOVA Partner Team and included in the NC NOVA Provider Information Manual.

a. If the new owner continues to meet the NC NOVA criteria, based upon the expedited review, the special licensure designation will remain in effect for the remainder of the two-year period.

b. If the new owner fails to meet NC NOVA criteria, the special designation document shall be immediately returned to the

Division of Facility Services. The new owner may reapply for NC NOVA designation under subsection (e) of this section.

(2) Within 30 days of the effective date of the change of ownership, if the new owner fails to notify the independent review organization in writing of the desire to retain the special licensure designation by undergoing an expedited review, the designation will become null and void, and the special designation document must be immediately returned to the Division of Facility Services."

SECTION 2.(a) In order to ensure continuity during the initial statewide implementation phase of NC NOVA, The Carolinas Center for Medical Excellence shall be designated as the independent review organization for NC NOVA through December 31, 2010. Beginning in 2009, the Division of Facility Services, with approval from the NC NOVA Partner Team, shall implement a competitive bid process to determine an independent review organization for a minimum of five years beginning in 2011.

SECTION 2.(b) During the period of the effective date of this act, through December 31, 2010, in the event The Carolinas Center for Medical Excellence determines it cannot continue conducting independent reviews, The Carolinas Center for Medical Excellence shall provide the Partner Team with a 12-month written notice of such intent in order to ensure sufficient transition time to select another independent review entity without any disruption of the NC NOVA program.

SECTION 3. This act becomes effective January 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1277*

Short Title:	NC NOVA-Special Voluntary Licensure Designat.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA NEW ORGANIZATIONAL VISION AWARD SPECIAL LICENSURE DESIGNATION, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

Whereas, "direct care workers" is a nationally recognized term referring to those paraprofessionals that are employed as nurse aides, personal care aides, personal care attendants, home health aides, in-home aides, habilitation aides, and other assistive personnel who provide hands-on care; and

Whereas, direct care workers are essential to the provision of care and an enhanced quality of life for long-term care consumers, whether they are receiving services provided in a home or community setting, or in a residential or institutional setting; and

Whereas, North Carolina, like many states, is experiencing shortages of direct care workers; and

Whereas, the need to attract and retain greater numbers of employees within this occupational category will continue for the foreseeable future; and

Whereas, a well-qualified, satisfied, stable, and adequate supply of direct care workers is a shared concern for employers, employees, consumers, families, and private and public payors of long-term care services received in home care agencies, adult care homes, and nursing facilities; and

Whereas, long-term care trade associations, providers, direct care workers, consumer advocacy organizations, researchers, the Department of Health and Human Services, and The Carolinas Center for Medical Excellence have worked together to develop a voluntary and comprehensive workplace culture change program known as the North Carolina New Organizational Vision Award (NC NOVA) to address known causes of direct care turnover for the purpose of improving the adequacy, stability, satisfaction, and quality of the direct care work; and

Whereas, NC NOVA has been identified as a potential national model for replication to improve direct care workforce retention through a comprehensive and voluntary workplace culture program by the Institute for the Future of Aging Services, the program office for the national Better Jobs Better Care initiative funded by the Robert Wood Johnson Foundation, and The Atlantic Philanthropies; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 6. North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation.

"**§ 131E-154.12. Title; purpose.**

(a) This Part shall be known as the "North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation."

(b) The purpose of this Part is to establish special licensure designation requirements for nursing homes and home care agencies licensed pursuant to this Chapter and adult care homes licensed pursuant to Article 1 of Chapter 131D. Application for the Special Licensure Designation is voluntary.

"**§ 131E-154.13. Definitions.**

The following definitions apply in this Part, unless otherwise specified:

(1) Independent Review Organization. – The organization responsible for the application, review, and determination process for NC NOVA designation.

(2) North Carolina New Organizational Vision Award (NC NOVA). – A special licensure designation for home care agencies and nursing homes licensed pursuant to this chapter, and adult care homes licensed pursuant to Article 1 of Chapter 131D, that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents.

(3) NC NOVA Partner Team. – The entity responsible for developing the criteria and protocols for the NC NOVA special licensure designation. The Partner Team is inclusive of representatives from the following organizations: Association for Home and Hospice Care of North Carolina, Direct Care Workers Association of North Carolina, Duke University Gerontological Nursing Program, Friends of Residents in Long Term Care, North Carolina Assisted Living Association, North Carolina Association of Long Term Care Facilities, North Carolina Association of Non-Profit Homes for the Aging, North Carolina Department of Health and Human Services, North Carolina Foundation for Advanced Health Programs, North Carolina Health Care Facilities Association, The Carolinas Center for Medical

Excellence, and the University of North Carolina at Chapel Hill – Institute on Aging.

(4) NC NOVA Provider Information Manual. – The document developed by the NC NOVA Partner Team that specifies the scope of criteria for NC NOVA designation as well as information and procedures pertaining to the application, review, determination, and termination process.

"**§ 131E-154.14. NC NOVA Program established.**

(a) The Department of Health and Human Services shall establish the NC NOVA program.

(b) The Department shall implement the NC NOVA program in accordance with the criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(c) Any information submitted by applicants or obtained by the independent review organization related to NC NOVA, as well as annual turnover data voluntarily submitted by home care agencies, adult care homes, and nursing facilities for the purposes of assessing statewide turnover trends, shall not be considered a public record under G.S. 132-1.

(d) Denial of a NC NOVA designation is not subject to Article 3 of Chapter 150B of the General Statutes.

(e) Any licensed home care agency, adult care home, or nursing home that is determined not to have met the criteria for NC NOVA designation may reapply at intervals specified by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(f) The Department of Health and Human Services, Division of Facility Services, shall issue a NC NOVA special licensure designation document to any licensed home care agency, adult care home, or nursing home that is determined by the independent review organization to have met the criteria for NC NOVA designation. The special licensure designation document shall be in addition to the operating license issued by the Division.

(g) The Division of Facility Services shall issue the NC NOVA special licensure document to successful applicants within 30 days of notification by the independent review organization.

(h) The NC NOVA special licensure designation shall be in effect for a two-year period unless the provider has a change in ownership.

(1) Upon a change in ownership, if the new owner wishes to continue the NC NOVA designation, the new owner must communicate the desire in writing to the independent review organization within 30 days of the effective date of the change of ownership and proceed with an expedited review in accordance with procedures detailed by the NC NOVA Partner Team and included in the NC NOVA Provider Information Manual.

a. If the new owner continues to meet the NC NOVA criteria, based upon the expedited review, the special licensure

designation will remain in effect for the remainder of the two-year period.

b. If the new owner fails to meet NC NOVA criteria, the special designation document shall be immediately returned to the Division of Facility Services. The new owner may reapply for NC NOVA designation under subsection (e) of this section.

(2) Within 30 days of the effective date of the change of ownership, if the new owner fails to notify the independent review organization in writing of the desire to retain the special licensure designation by undergoing an expedited review, the designation will become null and void, and the special designation document must be immediately returned to the Division of Facility Services."

SECTION 2.(a) In order to ensure continuity during the initial statewide implementation phase of NC NOVA, The Carolinas Center for Medical Excellence shall be designated as the independent review organization for NC NOVA through December 31, 2010. Beginning in 2009, the Division of Facility Services, with approval from the NC NOVA Partner Team, shall implement a competitive bid process to determine an independent review organization for a minimum of five years beginning in 2011.

SECTION 2.(b) During the period of the effective date of this act, through December 31, 2010, in the event The Carolinas Center for Medical Excellence determines it cannot continue conducting independent reviews, The Carolinas Center for Medical Excellence shall provide the Partner Team with a 12-month written notice of such intent, in order to ensure sufficient transition time to select another independent review entity without any disruption of the NC NOVA program.

SECTION 3. This act becomes effective January 1, 2007.

SENATE BILL 1277:
NC NOVA-Special Voluntary Licensure Designat

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 19, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 1277 establishes the North Carolina New Organizational Vision Award (NC NOVA) which is a voluntary special licensure designation for home care agencies, nursing homes and adult care homes. This bill is a recommendation from the NC Study Commission on Aging and is supported by the House Select Committee on Health Care.

BILL ANALYSIS:

SB 1277 adds a new Part to Article 5 of Chapter 131E establishing the North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation. The NC NOVA licensure designation will be rewarded to nursing homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents.

NC NOVA Program - Under G.S. 131E-154.14, the NC NOVA program will be implemented by the Department of Health and Human Services (DHHS) in accordance with criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual. G.S. 131E-154.13 contains definitions of the Provider Information Manual and the Partner Team, including an extensive list of those organizations represented on the Partner Team. The bill specifies that information submitted by applicants, obtained by the independent review organization, including turnover data, is not considered a public record under G.S. 132-1. Additionally, the bill provides that denial of NC NOVA designation is not subject to administrative hearings under the Administrative Procedure Act.

Licensure Designation – The special licensure designation is in addition to the operating license issued by the Division of Facility Services, DHHS. The Division will issue the NC NOVA licensure document to successful applicants within 30 days of notification and the designation is awarded for a two-year period unless there is a change in ownership. G.S. 131E-154.14(h) contains information on the NC NOVA process when a change in ownership occurs.

Independent Review Organization - The independent review organization is defined in the definitions section on page 2, lines 20-22. On page 4, Section 2 of the bill provides that The Carolinas Center for Medical Excellence will be designated as the independent review organization through December 31, 2010. (Section 2(b) contains the procedure if The Carolinas Center can no longer function in this capacity.) Section 2(a) provides for a bid process to determine an independent review organization for a minimum of five years beginning in 2011.

The effective date of the bill is January 1, 2007.

BACKGROUND:

NC NOVA is a voluntary special licensing award for home care agencies, adult care homes, and nursing homes. The project has been funded thus far by The Robert Wood Johnson Foundation and The Atlantic Philanthropies, with the Institute of the Future of Aging Services in Washington serving as the national

program office. Currently, NC NOVA is being piloted in 60 sites: 20 adult care homes, 20 nursing homes, and 20 home health agencies. The pilot phase lasted from July 2005 until May 2006.

The NC NOVA project focuses on direct care workers, a category which includes nurse aides, in-home aides/home health aides, and personal care aides/attendants. It is an incentive/reward based program with uniform criteria across long-term care settings. Review will be conducted by the Carolinas Center for Medical Excellence and a special license is issued for entities obtaining the NC NOVA designation.

North Carolina has high turnover rates for direct care workers, with average annual rates in 2004 as follows: 106% in adult care homes, 107% in nursing homes, and 41% in home care agencies. Additionally, direct care jobs are among the occupations with the largest projected job growth - it is anticipated that NC will need 30,590 additional direct care workers from 2002 to 2012.

NC NOVA has a training component as one of the four major domains. The program also includes pieces that assist direct care workers in efforts to address work/personal related barriers to success, and NC NOVA contains a peer mentor program. The training component includes criteria regarding development of a training plan, focus on person centered services, linkages with quality improvement initiatives and incorporating topics generated with input from direct care workers, use of adult education teaching principles, looking at low and high volume tasks that have associated risk, as well as other elements. The NC NOVA program also includes a management support element that includes offering case management or employee counseling to address logistical and emotional issues such as coordinating access to community services needed to overcome obstacles such as childcare, transportation, and housing. Additionally, management offers support groups for employees to address life/work issues, especially in the first 90 days of employment.

NC NOVA does need legislation, but State funds are not needed as the grant contains sufficient funds for operation in FY 2006-2007. The goal of the special licensure designation is to improve recruitment, retention, development, and job satisfaction of the direct care workforce; and improve the care provided to long-term care clients, residents, and patients. It is anticipated that NC NOVA will benefit providers, workers and consumers.

RECENT STUDIES ON DIRECT CARE STAFF

A February 2006 study prepared by the University of California, San Francisco contains information on direct care workers and factors affecting the projected need. Findings in the report include the following:

> "The demand for professionals (physicians, nurses, physical therapists, etc.) needed to care for the future aging population will be dwarfed by the vast number of non-licensed formal and informal caregivers need[ed] to care for the elderly in home and community settings."
>
> "Assuring the quality of care in nursing homes will continue to be a concern among policymakers and consumers."
>
> "Regardless of limitations of forecasting models, most experts agree that there will be an increasing demand for long-term care services, merely due the increasing numbers of the elderly in our population."

Additionally, three studies were recently released by Better Jobs Better Care initiative, funded by The Robert Wood Johnson Foundation and The Atlantic Philanthropies, http://www.bjbc.org/. These studies showed that, "Targeted training, accessible and hands-on continuing education and designated staff retention specialists can help increase direct care worker retention and help providers improve the quality of long-term care for the elderly and disabled persons."

Theresa Matula substantially contributed to this summary.

S1277e1-SMRD

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1277*

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

S1277-ARD-39 [v.2]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Senator _____

moves to amend the bill on page 3, lines 11-13, by rewriting the lines to read:
"(b) The Department shall adopt rules to implement the NC NOVA program in accordance with the criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.";
and on page 3, lines 19-20, by deleting the lines;
and by renumbering the remaining subsections accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1277*
PROPOSED COMMITTEE SUBSTITUTE S1277-PCS55490-SQ-59

Short Title: NC NOVA-Special Voluntary Licensure Designat. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA NEW ORGANIZATIONAL VISION AWARD SPECIAL LICENSURE DESIGNATION, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

Whereas, "direct care workers" is a nationally recognized term referring to those paraprofessionals that are employed as nurse aides, personal care aides, personal care attendants, home health aides, in-home aides, habilitation aides, and other assistive personnel who provide hands-on care; and

Whereas, direct care workers are essential to the provision of care and an enhanced quality of life for long-term care consumers, whether they are receiving services provided in a home or community setting, or in a residential or institutional setting; and

Whereas, North Carolina, like many states, is experiencing shortages of direct care workers; and

Whereas, the need to attract and retain greater numbers of employees within this occupational category will continue for the foreseeable future; and

Whereas, a well-qualified, satisfied, stable, and adequate supply of direct care workers is a shared concern for employers, employees, consumers, families, and private and public payors of long-term care services received in home care agencies, adult care homes, and nursing facilities; and

Whereas, long-term care trade associations, providers, direct care workers, consumer advocacy organizations, researchers, the Department of Health and Human Services, and The Carolinas Center for Medical Excellence have worked together to develop a voluntary and comprehensive workplace culture change program known as the North Carolina New Organizational Vision Award (NC NOVA) to address known causes of direct care turnover for the purpose of improving the adequacy, stability, satisfaction, and quality of the direct care work; and

Whereas, NC NOVA has been identified as a potential national model for replication to improve direct care workforce retention through a comprehensive and voluntary workplace culture program by the Institute for the Future of Aging Services, the program office for the national Better Jobs Better Care initiative funded by the Robert Wood Johnson Foundation, and The Atlantic Philanthropies; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 6. North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation.

"**§ 131E-154.12. Title; purpose.**

(a) This Part shall be known as the "North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation."

(b) The purpose of this Part is to establish special licensure designation requirements for nursing homes and home care agencies licensed pursuant to this Chapter and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes. Application for the Special Licensure Designation is voluntary.

"**§ 131E-154.13. Definitions.**

The following definitions apply in this Part, unless otherwise specified:

(1) Independent Review Organization. – The organization responsible for the application, review, and determination process for NC NOVA designation.

(2) North Carolina New Organizational Vision Award (NC NOVA). – A special licensure designation for home care agencies and nursing homes licensed pursuant to this Chapter, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes, that have been determined through written and on-site review by an independent review organization to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff and the care provided to long-term care clients and residents.

(3) NC NOVA Partner Team. – The entity responsible for developing the criteria and protocols for the NC NOVA special licensure designation. The Partner Team is inclusive of representatives from the following organizations: Association for Home and Hospice Care of North Carolina, Direct Care Workers Association of North Carolina, Duke University Gerontological Nursing Program, Friends of Residents in Long Term Care, North Carolina Assisted Living Association, North Carolina Association of Long Term Care Facilities, North Carolina Association of Non-Profit Homes for the Aging, North Carolina Department of Health and Human Services, North Carolina Foundation for Advanced Health Programs, North Carolina Health Care Facilities Association, The Carolinas Center for Medical

Excellence, and the University of North Carolina at Chapel Hill – Institute on Aging.

(4) NC NOVA Provider Information Manual. – The document developed by the NC NOVA Partner Team that specifies the scope of criteria for NC NOVA designation as well as information and procedures pertaining to the application, review, determination, and termination process.

"**§ 131E-154.14. NC NOVA program established.**

(a) The Department of Health and Human Services shall establish the NC NOVA program.

(b) The Department shall adopt rules to implement the NC NOVA program in accordance with the criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(c) Any information submitted by applicants or obtained by the independent review organization related to NC NOVA, as well as annual turnover data voluntarily submitted by home care agencies, adult care homes, and nursing facilities for the purposes of assessing statewide turnover trends, shall not be considered a public record under G.S. 132-1.

(d) Any licensed home care agency, adult care home, or nursing home that is determined not to have met the criteria for NC NOVA designation may reapply at intervals specified by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.

(e) The Department of Health and Human Services, Division of Facility Services, shall issue a NC NOVA special licensure designation document to any licensed home care agency, adult care home, or nursing home that is determined by the independent review organization to have met the criteria for NC NOVA designation. The special licensure designation document shall be in addition to the operating license issued by the Division.

(f) The Division of Facility Services shall issue the NC NOVA special licensure document to successful applicants within 30 days of notification by the independent review organization.

(g) The NC NOVA special licensure designation shall be in effect for a two-year period unless the provider has a change in ownership.

(1) Upon a change in ownership, if the new owner wishes to continue the NC NOVA designation, the new owner must communicate the desire in writing to the independent review organization within 30 days of the effective date of the change of ownership and proceed with an expedited review in accordance with procedures detailed by the NC NOVA Partner Team and included in the NC NOVA Provider Information Manual.

a. If the new owner continues to meet the NC NOVA criteria, based upon the expedited review, the special licensure designation will remain in effect for the remainder of the two-year period.

b. If the new owner fails to meet NC NOVA criteria, the special designation document shall be immediately returned to the Division of Facility Services. The new owner may reapply for NC NOVA designation under subsection (e) of this section.

(2) Within 30 days of the effective date of the change of ownership, if the new owner fails to notify the independent review organization in writing of the desire to retain the special licensure designation by undergoing an expedited review, the designation will become null and void, and the special designation document must be immediately returned to the Division of Facility Services."

SECTION 2.(a) In order to ensure continuity during the initial statewide implementation phase of NC NOVA, The Carolinas Center for Medical Excellence shall be designated as the independent review organization for NC NOVA through December 31, 2010. Beginning in 2009, the Division of Facility Services, with approval from the NC NOVA Partner Team, shall implement a competitive bid process to determine an independent review organization for a minimum of five years beginning in 2011.

SECTION 2.(b) During the period of the effective date of this act, through December 31, 2010, in the event The Carolinas Center for Medical Excellence determines it cannot continue conducting independent reviews, The Carolinas Center for Medical Excellence shall provide the Partner Team with a 12-month written notice of such intent in order to ensure sufficient transition time to select another independent review entity without any disruption of the NC NOVA program.

SECTION 3. This act becomes effective January 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1274*

Short Title:	LTC Fines Posted on Internet.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, TO POST THE FINES AND PENALTIES ASSESSED TO LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Facility Services, shall establish and maintain a list of substantiated infractions, fines, and penalties assessed to long-term care facilities. The list shall be accessible on the Internet and implemented not later than October 15, 2006. The Department shall report on the implementation of the list to the North Carolina Study Commission on Aging not later than November 1, 2006.

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

SENATE BILL 1274:
LTC Fines Posted on Internet

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 2, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Sara Kamprath
Version:	First Edition		Committee Staff

SUMMARY: Senate Bill 1274 directs the Department of Health and Human Services, Division of Facility Services, to maintain a list on the Internet of infractions, fines and penalties assessed to long-term care facilities. The bill is a recommendation of the Study Commission on Aging.

BILL ANALYSIS: Senate Bill 1274, implements a recommendation of the Study Commission on Aging, directing the Department of Health and Human Services (Department), Division of Facility Services, to create and maintain a list of the substantiated infractions, fines, and penalties that are assessed to long-term care facilities. The list shall be available on the Internet by October 15, 2006. The Department shall report on the implementation of the list to the Study Commission on Aging by November 1, 2006.

EFFECTIVE DATE: The act is effective when it becomes law.

BACKGROUND: The Study Commission on Aging heard a presentation on March 15, 2006 from the Division of Facility Services that the fines and penalties assessed to long-term care facilities are not currently posted in a location that is accessible to the public. The Department is studying ways to post penalties on its website for public use. Other State agencies, especially the Department of Environment and Natural Resources, post this kind of information on the Internet. Currently consumers evaluating nursing homes can access information on the internet regarding nursing homes. The "Nursing Home Compare" on the Medicare website contains information on regulatory requirements that nursing homes failed to meet, but the site does not provide an entire inspection report. According to the website, "a complete inspection report and the nursing home's corresponding plan of correction to address the deficiencies found during the inspection are available from the State survey agency or from the nursing home itself. In addition, each nursing home that provides Medicare or Medicaid services is required to make the results of its last full inspection available onsite for public review." The Nursing Home Compare can be found at: http://www.medicare.gov/NHCompare/home.asp The Commission believes that timely posting of the fines and penalties would be a valuable resource to consumers.

S1274e1-SMRJ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1275*

Short Title:	Health Care Personnel Registry Expansion.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE HEALTH CARE PERSONNEL REGISTRY BY AMENDING THE DEFINITIONS OF HEALTH CARE FACILITIES AND HEALTH CARE PERSONNEL, TO PROHIBIT THE EMPLOYMENT BY HEALTH CARE FACILITIES OF ANY PERSON WHO HAS A SUBSTANTIATED FINDING ON THE HEALTH CARE PERSONNEL REGISTRY, AND TO APPROPRIATE FUNDS TO THE DIVISION OF FACILITY SERVICES FOR STAFFING, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(8) Residential Facilities as defined in G.S. 122C-3(14)e.
(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(10) Licensable Facilities as defined in G.S. 122C-3(14)b.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
(12) Community Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.~~the following are considered to be "health care personnel":~~

~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~

~~(2) A nurse aide.~~

~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~

~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) A health care facility shall not employ any person for whom a substantiated finding has been entered on the Health Care Personnel Registry. Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2006-2007 fiscal year, to be used to establish positions to handle increases in allegations and investigations.

SECTION 3. Section 1 of this act becomes effective October 1, 2006. Section 2 of this act becomes effective July 1, 2006. The remainder of this act is effective when it becomes law.

SENATE BILL 1275:
Health Care Personnel Registry Expansion

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 6, 2006
Introduced by:	Senator Dannelly	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 1275 would expand the definition of "health care facilities", expand the definition of "health care personnel", and include an appropriation of $1,700,000 for the 2006-2007 fiscal year for the establishment of positions to handle increases in allegations and investigations. This bill is a recommendation from the Study Commission on Aging. If this bill receives a favorable report, it has a serial referral to House Appropriations.

[As introduced, this bill was identical to H2050, as introduced by Reps. Earle, Weiss, Bordsen, England, which is currently in House Aging .]

CURRENT LAW:

The Department of Health and Human Services maintains a Health Care Personnel Registry that contains the names of all health care personnel working in health care facilities that have been subject to findings, or have been accused of and an investigation has been required, for the following acts:

- Neglect or abuse of a resident in a health care facility or person to whom home care (G.S. 131E-136) or hospice services (G.S. 131E-201) are being provided.
- Misappropriation of the property of a resident in a health care facility or resident of a place where home care or hospice services are being provided.
- Misappropriation of the property of the health care facility.
- Diversion of drugs belonging to a health care facility or to a patient or client.
- Fraud against a health care facility or against a patient or client for whom the employee is providing services

Individuals subject to the provisions of the Health Care Personnel Registry are defined by statute. G.S. 131E-256(b) defines entities that are considered "health care facilities" and G.S. 131E-256(c) defines individuals that are considered "health care personnel."

BILL ANALYSIS:

Section 1 would rewrite G.S. 131E-256(b) to add the following facilities to the list of "health care facilities" that would be included in the Health Care Personnel Registry:

- Licensable Facilities (defined in G.S. 122C-3(14)b) which includes any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, including a "licensable facility", which provides services for one or more minors or for two or more adults, including day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities.

- Multiunit Assisted Housing with Services (G.S. 131DD-2).
- Community Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
- Agencies providing in-home aid services funded through the Home and Community Care Block Grant (G.S.143B-181.1(a) 11).

The bill would revise G.S. 131E-256(c) to amend the definition of "health care personnel" broadening it to include any unlicensed staff of a health care facility (defined in G.S. 131E-256(b)) that has direct access to residents, clients, or their property.

- Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact
    - with an individual
    - or an individuals property,

  when that individual is a resident or person to whom services are provided.

The current definition in the statutes primarily pertains to those aides providing hands-on care (i.e. adult care home personal aides that supervise or perform specific tasks, nurse aides, in-home aides, or in-home personal care aides who provide hands on services, and unlicensed assistant personnel who provide hands on care.)

The bill would add language to G.S. 131E-256(d2) to prohibit a health care facility from employing any person for whom a substantiated finding has been entered on the Health Care Personnel Registry.

Section 2 would appropriate $1,700,000 to the DHHS, Division of Facility Services for the 2006-2007 fiscal year to be used to establish positions to handle increases in allegations and investigations. (See related detail provided in the second paragraph of the background information, below.)

EFFECTIVE DATE:
Section 1 of Senate Bill 1275 would become effective October 1, 2006, Section 2 would become effective July 1, 2006, and the remainder of the bill would be effective when it becomes law.

BACKGROUND:
S.L. 2005-276, Section 10.40A(q) required the Department of Health and Human Services (DHHS) to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings, including unlicensed health care settings, that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. On January 18, 2006, DHHS presented to the Study Commission on Aging, a report that included the changes contained in this bill.

Additionally, DHHS believes that they will need additional staff resources to process the increased number of allegation reports as a result of the expansion, and to manage expansions that have occurred over the last five years. (The Department reports that in the last five years, allegations have increased 280% and there has been a 62% increase in cases needing investigations.) The Department estimated that it would need $1.7 million for: 18 investigator positions, 3 regional supervisor/investigator positions, and 6 administrative support positions.

Theresa Matula, staff to the House Aging Committee, substantially contributed to this summary.

S1275e1-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1280*

Short Title:	DHHS Evaluate Telemonitoring.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO EVALUATE THE USE OF TELEMONITORING EQUIPMENT, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall evaluate the use of telemonitoring equipment as a tool to improve the health of home-based individuals through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The evaluation must include a representative number of older adults. The Department shall report to the Study Commission on Aging by August 1, 2007. The report shall include findings and recommendations on the cost-effectiveness of telemonitoring and the benefits to individuals and healthcare providers.

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

SENATE BILL 1280:
DHHS Evaluate Telemonitoring

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 2, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 1280 directs the Division of Medical Assistance to evaluate the cost effectiveness and benefits of the use of telemonitoring equipment and report its findings to the Study Commission on Aging.***

This act is effective when it becomes law.

BILL ANALYSIS: As recommended by the Study Commission on Aging, the bill requires the Department of Health and Human Services, Division of Medical Assistance to evaluate the use of telemonitoring equipment. The evaluation will include a representative number of older adults and shall focus on whether or not the use of this equipment results in decreased hospital rates and increased stabilization rates for home-based individuals. The bill requires the Department to report its findings to the Study Commission on Aging by August 1, 2007.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

This bill is a recommendation of the Study Commission on Aging. During the interim, the Commission heard a presentation on the use of telemonitoring equipment which is capable of monitoring and conveying vital signs, providing patient education, and assisting individuals with medication compliance.

The technology varies, but equipment can capture the following range of items:

- heart rate
- weight
- lung function
- blood pressure
- temperature
- heart rhythms
- oxygen saturation
- glucose count

Once captured, the data can be transmitted via digital wireless technology or traditional phone lines for review. If vital signs are outside the pre-established ranges set by the physician or nurse, the patient may be contacted and provided any necessary follow-up care.

S1280e1-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1280*
PROPOSED COMMITTEE SUBSTITUTE S1280-CSSQ-57 [v.1]

6/6/2006 4:28:16 PM

Short Title: DHHS Evaluate Telemonitoring. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO ESTABLISH A PILOT PROGRAM TO EVALUATE THE USE OF TELEMONITORING EQUIPMENT IN HOME CARE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall implement a pilot program to evaluate the use of telemonitoring equipment in home care services. As determined by the Division, the Department shall provide remuneration to home care agencies for participation in the pilot program. The pilot program shall be implemented by October 1, 2006 and shall evaluate the use of telemonitoring equipment as a tool to improve the health of home care clients through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The evaluation must include a representative number of older adults. The Department shall report to the Study Commission on Aging by August 1, 2007. The report shall include findings and recommendations on the cost-effectiveness of telemonitoring and the benefits to individuals and healthcare providers.

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

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pam Seamans	NC Alliance for Health
Lynette D.	HHS
Kellie Visker	AARP
Deanna D. Hardee	AARP
Mary Bell	AARP-NC
Crystal Hopson	Covenant
Mary Williams	ACS-Cancer Society
John Thompson	ACS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carolyn Jorenson	NCNA
Rebecca Troutman	NCACC
Guy Rowing	Albins & Co.
Michelle Judkins	intern
Jesse Gwynn	DHHS
[signature]	SA
William L Lawrence	DMH
Patricia A. Young	FRLTC
Wes Robinson	NCHS
Barry Stowe	NCMS
Mari Smith	NCSA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	WCPSS
N. Rajan	North Carolina Medical Society
Dave Code	"
KRISTEN SHIPHERD	NC Medical Society
George Huffmon	NC Medical Society
Allison Clegg	NC Medical Society
Frank Melvin	N.C. Med Society.
Alma Jenkins	N.C. Med. Society
Yasmeen Kham	NC. Medical Society
Elizabeth Tilson	NC Medical Society
LIZ KNAUF	NCMedical Soc

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Edwards	UNC-CH Daily Bulletin
David Lewis	N.C. Medical Society
Peg O'Connell	CCMT
Brian Wright	Conservation Council
Mike Nelson	Conservation Council
Bill Wilson	AARP
CP Medlin	NCATL
Marcus Davis	NC State Health Plan
Anthony Starr	Town of Catawba
Tracy Kimbrell	Parker Poe
	Bode Call & Stroupe

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Jo Horne	NCMS
Pru-Ann Coe	NCPA
Caly Wiggins	Gov. office
Alex Sewell	Womble Carlyle
Jerry Lopp	NCALA
[illegible]	DHHS-DFS
Donna White	DAAS
Jim Edgerton	DHHC
John McMillan	NFFS
STEVE KEENE	NC MEDICAL SOCIETY
BRIAN SHANK	ASTRAZENECA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

JUNE 7, 2006 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Valenza	
Charlotte Graham	Am. Heart Assoc.
Alyn Berry	Civitas Institute
Charlene Carey	NC Right to Life
Kathy Seibel	NC Med Soc.
Pete Callahan	Wachovia / Greensboro Chamber
Jim Brogden	US LEC / Greensboro Chamber
Pat Prudence	NCNA
Rosemary Wander	UNCG
Melissa Westmoreland	Greensboro Chamber of Commerce

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robin Huffman	NC Psychiatric Assoc
[illegible]	NCCLP
Angie Hairr	Margin Taylor
TOMMY SUTER	WYETH
[illegible]	[illegible]
Barbara Carrales	BSCOR
Mary Edwards	DMHS
Joanne Stevens	NCNA
[illegible]	NCALTCF
[illegible]	[illegible]
Polly Williams	Friends of Residents / NC Justice Center

investigated not accused - it's a matter of wording

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 7, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner + Spruill
Dana Sipes	Smith Ades

Senate Health Care Committee
Wednesday, June 14, 2006, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 2120	Strengthen LOC Oversight Role.	Representative Parmon Representative Steen, II Representative Farmer-Butterfield Representative Insko
HB 1343	Health Insur./Prompt Pay Correction.	Representative Nye
SB 1487	Dental Hygiene Law Changes.	Senator Nesbitt, Jr.
HB 1133	County Gov't. Criminal Records Checks.	Representative Dickson Representative Lucas Representative McAllister Representative Glazier

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 14, 2006

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

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

S.B. **1487** Dental Hygiene Law Changes.

Draft Number:	PCS65607
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

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

H.B. **1343** Health Insur./Prompt Pay Correction.

Draft Number:	PCS80660
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

H.B. **2120** Strengthen LOC Oversight Role.

Draft Number:	PCS10625
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1133** County Gov't. Criminal Records Checks.

Draft Number:	PCS70778
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 4

Committee Clerk Comments:

Senate Health Care Committee
Wednesday June 14, 2006
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 14, 2006, in Room 544 of the Legislative Office Building, with thirteen members present. Senator Stan Bingham presided. Senator Bingham and Senator William R. Purell, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Doctor Palmer Edwards with NC Psychiatric Associations and all the members of the Psychiatric Associations were welcomed.

Representative Glazier was recognized to present HB 1133, ***County Government Criminal Records Checks***, and Senator Purcell moved to adopt the PCS for discussion. Representative Glazier stated the bill had been changed and the Proposed Committee Substitute title reads ***Designate the General Assembly Buildings Nonsmoking***. Representative Glazier asked that Pam Seaman, Executive Director of NC Alliance for Health, and Doctor Janna Johnson, Medical Director of the Tobacco Prevention and Control Branch of the NC Department of Health and Human Services, to be called upon to speak. Representative Glazier pointed out that The NC General Assembly is about leadership and it is where leaders in businesses, education, commerce, and government convene to examine how to make North Carolina a better place to live and to work. Last year 46,000 middle school students visited The NC General Assembly buildings, almost 1,200 high school students paged in these buildings, and tens of thousands of elementary students visited. There are five to six hundred full time state employees and staff, and all deserve protections. Doctor Janna Johnson, Pulmonologist with the Tobacco Prevention and Control Branch serving as the Medical Director of DHHS, stated that secondhand smoke is a serious health problem and causes a significant number of deaths each year in this country. An estimated 35,000 deaths from heart disease and 3,000 deaths from lung disease, all among non-smokers, occur each year. Among children, second health smoke causes an alarming number of illnesses. Smoke-Free Environments give a two-for-one benefit, eliminating the second smoke exposure and eliminating the smoking role model that influences young people to start smoking. Recent findings have concluded that brief exposures of second-hand smoke can cause heart attacks in people who have pre-existing heart disease or who have risk factors for heart disease such as high blood pressure, high cholesterol or diabetes. These findings have led the CDC to conclude the following: that all patients at increased risk of coronary heart disease or with known coronary heart disease should be advised to avoid all indoor environments that permit smoking. Smoke free policies therefore not only prevent the development of heart disease but can actually prevent heart attacks in those that are at risk for them. Pam Seamans, Executive Director of NC Alliance for Health, which is a statewide collation promoting tobacco-use prevention and cessation policies for healthier North Carolina, stated, The Alliance

members include The American Heart Association, The American Cancer Society, The NC Pediatrics Society, and dozens more. Pam expressed grave concerns of children visiting the General Assembly and urged the committee members to give a favorable report to HB 1133. Senator Dorsett stated that for some time other buildings have been regulated and wants the legislators to protect themselves and would like to move for a favorable report, which passed unanimously.

Senator Bingham asked for a motion to adopt the PCS for discussion for House Bill 1343, ***Health Insur./Prompt Pay Correction,*** which changed the title to ***Dental Intern Permits***. Senator Purcell made the motion, which passed. Senator Purcell then was recognized to explain the bill. Senator Purcell stated that currently the North Carolina State Board of Dental Examiners Board could issue an annual intern permit to persons who are not licensed to practice dentistry in the state of NC if they are a graduate of a dental school or college or institution that is approved by the board. A dentist holding an intern permit can only practice under the supervision of a dentist duly licensed to practice in the state of NC. There are other restrictions also. An intern permit is issued for one year at a time and can be renewed up to six years. This bill extends the authority of the Board of Dental Examiners to allow the board in its discretion and upon request of the employing institution to renew intern permits beyond the seventy-two months for a period of one year at a time. It also prohibits the board from issuing intern permits to persons who have attempted and failed the board-approved examination. The employing institution here might be a state prison or state hospital. This bill is needed because there are many hard-to-staff areas in NC, especially in rural areas. Senator Allran asked if anyone from the Dental Society was there to speak to this bill. William Potter, representing the North Carolina Dental Society, stated they have endorsed the bill and there is no opposition. Senator Dorsett moved for a favorable report, which passed.

Senator Nesbitt was recognized to explain HB 2120, ***Strengthen LOC Oversight Role***, and he moved to adopt the PCS for discussion. Senator Nesbitt stated that the first sections of the PCS strengthens the Legislative Oversight Committee (LOC) and gives it the power to functions with other oversight commissions. The bill identifies some things the LOC should study, one being the idea of the Local Management Entities, LMEs, controlling the use of hospital beds. LMEs are area authorities and county programs. Now there are no incentives not to send someone to the state hospital. When clients are sent to the state hospitals the cost comes from the state's budget, not the local budget. The second provision is to consider whether more LMEs should operate under a wavier, like one in NC, which operates free from the department, in that they manage their own money and their own Medicaid. Third is a recommendation to study removing some of the categories where the money is stored, it being like a silo and the money cannot be moved from one the other. The reason for the PCS is to add a recommendation to study the funding of Drug Courts and how they operate. This bill is a recommendation from the Joint Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. Senator Malone raised an issue about giving strong consideration about separating disabilities that can be improved from disabilities that are

not expected to get better, like from birth to grave. He would like to study the concept of separating the two. Senator Malone stated he would be satisfied in doing this and did not send forth an amendment. Senator Jacumin made the motion unfavorable as to Bill, but favorable as to Committee Substitute Bill. Motion carried.

Senator Nesbitt was recognized to present, SB 1487, ***Dental Hygiene Law Changes.*** Senator Nesbitt presented an amendment and was asked to explain the amendment. On page 1, line 27, the word "restorative" was removed because Dental Hygienist does not do any restorative clinical. Senator Berger made a motion to adopt the amendment, which passed. Senator Nesbitt was asked to explain the bill, which was a recommendation from the Joint Legislative Administrative Procedure Oversight Committee. The APO Committee consists of House and Senate Members that meet and oversee proper rule making and handle problems with state agencies. In this case they had authorized The Dental Board to handle licensing Dental Hygienist. The Dental Board was to charge a fee no more than $350.00 and they had been charging $170.00. Early this year they decided to go to a regional examination and then the Dental Hygienist would have to pay the fee to the regional examiner, which was $700.00. The Community Colleges and The Dental Hygiene Association and everyone were upset about this. The APO Committee looked at the Regional Examination and was less than enthusiastic. Normally there would be strength in Regional Examinations because the licensee would be licensed in more than one state. But in this case it was the beginning of a Regional Examination and NC would have been included with Puerto Rico, Louisiana, and Mississippi. The APO Committee took the position that they could not delegate the examination to someone who would charge $700.00 if the maximum was set at $350.00. In the process the date required, by statute, to have your application into the state was missed because they did not get a resolution of this in time for some people to know that they could still take the state exam. This bill allows the Hygienists who applied late to go ahead and take the examination this year. Senator Dorsett was on the Administrative Procedure Oversight Committee and felt this was thoroughly discussed and moved for a favorable report. The motion being to adopt Senate Bill 1487 as amended, to be rolled into a new PCS, unfavorable to the original bill and re-refer to Appropriation/Base Budget. The motion carried.

The meeting adjourned at 12:00 Noon.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1133*

Committee Substitute Favorable 5/2/05

Short Title: County Gov't. Criminal Records Checks. (Public)

Sponsors:

Referred to:

April 6, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING CRIMINAL RECORDS CHECKS FOR COUNTY GOVERNMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 114-19.14 reads as rewritten:

"**§ 114-19.14. Criminal record checks for ~~municipalities.~~municipalities and county governments.**

The Department of Justice may provide to a city or county from the State and National Repositories of Criminal Histories the criminal history of any person who applies for employment with the ~~city.~~ city or county. The city or county shall provide to the Department of Justice, along with the request, the fingerprints of the applicant, a form signed by the applicant consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The city or county shall keep all information obtained pursuant to this section confidential. The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 2. Article 5 of Chapter 153A of the General Statues is amended by adding a new section to read:

"**§ 153A-94.2. Criminal history record checks of employees permitted.**

The board of commissioners may adopt or provide for rules and regulations or ordinances concerning a requirement that any applicant for employment be subject to a criminal history record check of State and National Repositories of Criminal Histories conducted by the Department of Justice in accordance with G.S. 114-19.14. The local or

regional public employer may consider the results of these criminal history record checks in its hiring decisions."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1133*

Committee Substitute Favorable 5/2/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H1133-CSRD-40 [v.3]

5/31/2006 3:26:02 PM

Short Title: Designate General Assembly Bldgs Nonsmoking. (Public)

Sponsors:

Referred to:

April 6, 2005

A BILL TO BE ENTITLED

AN ACT TO DESIGNATE ALL AREAS OF ANY BUILDING OCCUPIED BY THE GENERAL ASSEMBLY AS NONSMOKING AREAS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-597 reads as rewritten:

"**§ 143-597. Nonsmoking areas in State-controlled buildings.**

(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, enclosed physical education facilities, enclosed student recreational centers, laboratories, or residence halls, provided that each constituent institution shall make a reasonable effort to provide

residential smoking rooms in residence halls in proportion to student demand for those rooms.

(a1) All areas of any building occupied by the General Assembly shall be designated as nonsmoking areas.

(b) Any area designated as nonsmoking or smoking shall be established by the appropriate department, institution, agency, or person in charge of the State-controlled building or ~~area.~~ area, except as specified in subsection (a1). The person in charge of the building shall conspicuously post or cause to be posted, in any area designated as a smoking or nonsmoking area, one or more signs stating that smoking is or is not permitted in the area.

(c) Where a nonsmoking area is designated, existing physical barriers and ventilation systems shall be used where appropriate to minimize smoke from adjacent areas. This subsection shall not be construed to require fixed structural or other physical modification in providing these areas or to require installation or operation of any heating, ventilating, or air-conditioning system in any manner which adds expense."

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

HOUSE BILL 1133:
Designate General Assembly Bldgs Nonsmoking

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 13, 2006
Introduced by:	Reps. Dickson, Lucas, Glazier, McAllister	**Summary by:**	Ben Popkin
Version:	PCS to Second Edition H1133-CSRD		Committee Counsel

SUMMARY: The Proposed Committee Substitute to House Bill 1133 would require that all areas of any building occupied by the General Assembly be designated as nonsmoking areas. The bill would be effective when it becomes law.

CURRENT LAW: Article 64 of the General Statutes addresses the needs and concerns of both smokers and nonsmokers in public places by providing for designated smoking and nonsmoking areas[1]. A list of buildings owned, leased or occupied by State government which may be designated as nonsmoking areas is set forth in G.S. 143-597(a) and includes: museums, libraries, and UNC health services facilities. Areas designated as either nonsmoking or smoking areas are to be established by the "appropriate department, institution, agency, or person in charge of the State-controlled building or area."[2] Nonsmoking areas must be visibly posted as such, and requirements for separate ventilation systems and physical barriers between nonsmoking and adjacent smoking areas are provided for in the statute[3].

Violation by continuing to smoke in a nonsmoking area after having been given notice to stop smoking is an infraction punishable by a fine of not more than $25.00[4]. Local ordinances, laws or rules passed on or after October 15, 1993 regulating smoking may not contain restrictions exceeding those of Article 64 and may only address smoking in specifically identified types of facilities[5].

An itemized list of facilities specifically exempted from regulation by the provisions of Article 64 is set forth in G.S. 143-599, including the following: any primary or secondary school, child care center (teacher's lounge excepted), enclosed elevators, public school buses, hospitals, nursing homes, rest homes, local health departments, organizations intended to discourage tobacco use, and tobacco manufacturing, processing and administrative facilities.

BILL ANALYSIS: The PCS to House Bill 1133 would add a new subsection to G.S. 143-597(a1) that would require that, "All areas of any building occupied by the General Assembly shall be designated as nonsmoking areas." The designation of these areas as nonsmoking would be required by statute and, so, would not need to be established by "the appropriate department, institution, agency, or person in charge of the State-controlled building or area" as is the case with the State-controlled buildings listed in G.S. 143-597(a).

EFFECTIVE DATE: This act would be effective when it becomes law.

H1133e2-SMRD-CSRD

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[1] G.S. 143-595.
[2] G.S. 143-597(b).
[3] G.S. 143-597(b) & (c).
[4] G.S. 143-598.
[5] G.S. 143-601(b).

North Carolina Alliance for Health

Why North Carolina's General Assembly Buildings Should be Smoke-Free

(March 2006)

Why the General Assembly Buildings Should be Smoke-Free:

- Everyone has the right to breathe clean air. There are 500-600 full-time employees who work in the General Assembly buildings who deserve protection from the harmful effects of secondhand smoke. House and Senate members made their chambers smoke-free in 2004 and 2005, respectively. Legislative employees deserve the same protection.
- As little as thirty minutes of exposure can trigger a heart attack in someone with heart disease or risk factors for heart disease. The Centers for Disease Control and Prevention (CDC) warns that "...all patients at risk of coronary heart disease or with known coronary artery disease should be advised to avoid all indoor environments that permit smoking"[1].
- In 2005 1,806 school groups, or 46,232 middle school students, visited the General Assembly building, with the highest volume months being in March, April and May when the legislature was in session.

Secondhand Smoke is Harmful to Health

- Every year secondhand smoke causes the deaths of 35,000 Americans[2]. In North Carolina, 1,220 to 2,180 adults, children and babies die each year from others' smoking[3].
- Nonsmokers exposed to secondhand smoke have been shown to have many of the same tobacco-related diseases as active smokers. Secondhand smoke has been shown to increase nonsmokers' risk of heart disease, stroke, and cancer[3].

Cardiovascular Disease/ Stroke

- As little as thirty minutes of exposure can trigger a heart attack in someone with heart disease or risk factors for heart disease[1].
- Community restrictions on smoking in public places have reduced the incidence of heart attacks among bartenders by 40%[4].

Cancer

- Secondhand smoke exposure has been shown to cause lung and nasal cancer in nonsmoking adults[3]. An estimated 3,000 new cases of lung cancer per year are as a result of secondhand smoke exposure[5].
- Non-smokers routinely exposed to secondhand smoke at work see their risk of lung cancer increase by at least 50% [6 7 8].

Secondhand Smoke Dramatically Affects Youth

- According to the National Cancer Institute and the Environmental Protection Agency, young people exposed to secondhand smoke are at increased risk for lower respiratory infections, chronic ear infections, asthma, abdominal obesity, and hyperglycemia [9] and can have impaired ability to learn, including reading deficits and deficits in math and reasoning[10].
- Studies have shown that children exposed to secondhand smoke are more likely to start smoking as adolescents[11].
- Pregnant women exposed to secondhand smoke are at increased risk to have low birth-weight babies.[12]

Ventilation Systems Do Not Protect People from Exposure to Secondhand Smoke

- According to the CDC, there is no safe level of exposure to secondhand smoke[6].
- The American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) is the international standard-setting body for a number of engineering practices, including ventilation. According to ASHRAE, ventilation and other air filtration technologies cannot eliminate all the health risks caused by secondhand smoke exposure, and because there is no safe level of exposure to secondhand smoke, tobacco smoke does not belong in indoor areas[13].

For more information, contact NC Alliance for Health

ncalliance@heart.org 919-463-8328

[1] Pechacek, TF and Babb, S *How acute and reversible are the cardiovascular risks of secondhand smoke?* BMJ. 2004 Apr 24;328(7446):980-3.
[2] National Cancer Institute. *Health Effects of Exposure to Environmental Tobacco Smoke.* Smoking and Tobacco Control Monograph No. 10. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 1999.
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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1343
Second Edition Engrossed 5/31/05

Short Title:	Health Insur./Prompt Pay Correction.	(Public)
Sponsors:	Representative Nye.	
Referred to:	Health.	

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE PROMPT PAY STATUTE TO ALLOW PARTIES TO AGREE TO CERTAIN TERMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225 is amended by adding the following new subsection to read:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

...

"(n) The provisions of this section may not be amended by contract including the notification requirements under subsection (b) of this section, requirements to specify good faith reason or reasons for denial, processes for denying and reopening a claim, payment of interest as specifically described under subsection (e) of this section, requirements that insurers permit at least 180 days after the date of provision of care or patient discharge as described in subsection (f) of this section, provision of claim status reports under subsection (g) of this section. To the extent that insurers have contract provisions in existence or execute in the future specific provisions in provider contracts that are less favorable to providers than this section, those provisions shall be superseded by the more favorable provisions in this section, and health care providers shall be notified in writing by insurers within 30 days of the superseded provisions."

SECTION 1.1. G.S. 58-3-225(b) reads as rewritten:

"(b) An insurer shall, within ~~30~~ 15 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) Payment of the claim.

(2) Notice of denial of the claim.

(3) Notice that the proof of loss is inadequate or incomplete.

(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.

(5) Notice that coordination of benefits information is needed in order to pay the claim.

(6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all."

SECTION 2. G.S. 58-3-225(f) reads as rewritten:

"(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. However, except as otherwise provided in subsection (n) of this section, an insurer may not limit the time in which claims may be submitted to fewer than 180 days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required."

SECTION 3. This act is effective when it becomes law and applies to contracts executed on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1343
Second Edition Engrossed 5/31/05
PROPOSED SENATE COMMITTEE SUBSTITUTE H1343-CSSQ-60 [v.2]

6/7/2006 4:54:05 PM

Short Title: Dental Intern Permits. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS TO EXTEND THE PERIOD IN WHICH A PERSON MAY RENEW AN INTERN PERMIT UNDER THE LAWS REGULATING THE PRACTICE OF DENTISTRY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-29.4(1) reads as rewritten:

"The North Carolina State Board of Dental Examiners may, in the exercise of the discretion of said Board, issue to a person who is not licensed to practice dentistry in this State and who is a graduate of a dental school, college, or institution approved by said Board, an intern permit authorizing such person to practice dentistry under the supervision or direction of a dentist duly licensed to practice in this State, subject to the following particular conditions:

(1) An intern permit shall be valid for no more than one year from the date ~~of issue thereof; provided, however, that the~~the permit was issued. The Board may, in its discretion, renew ~~such~~ the permit for not more than five additional one-year ~~periods; and, provided, further, that~~periods. However, no person who has attempted and failed a Board-approved written or clinical examination shall be granted an intern permit or intern permits embracing or covering an aggregate time span of more than 72 calendar ~~months;~~months. An intern permit holder who has held an unrestricted dental license in a Board-approved state or jurisdiction for the five years immediately preceding the issuance of an intern permit in this State may, in the Board's discretion, have the intern permit renewed for additional one-year periods beyond 72 months if the intern permit holder's approved employing institution comes before

the Board on the permit holder's behalf for each subsequent annual renewal;

...."

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

HOUSE BILL 1343:
Dental Intern Permit

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 7, 2006
Introduced by:	Rep. Nye	**Summary by:**	Shawn Parker
Version:	PCS to Second Edition H1343-CSSQ-60		Legislative Analyst

SUMMARY: The Senate Proposed Committee Substitute to House Bill 1343 allows the State Board of Dental Examiners to extend the number of annual renewals of an intern permit in certain situations.

CURRENT LAW: Currently, the North Carolina State Board of Dental Examiners (Board) can issue an annual intern permit to persons who are not licensed to practice dentistry in this State and are graduates of approved dental schools. The permit which can be renewed annually for up to 5 years authorizes the individual to practice dentistry under the supervision or direction of a dentist who is duly licensed to practice in North Carolina.

BILL ANALYSIS: The bill would authorize the Board to extend an issued intern permit beyond the aggregate time span of 72 months subject to the following conditions:

- The permit holder has held an unrestricted dental license in a Board-approved state or jurisdiction for the five years immediately preceding the issuance of the intern permit;
- The permit holder's approved employing institution comes before the Board on the permit holder's behalf for each subsequent review; and
- The permit holder has not attempted and failed a Board-approved written or clinical exam.

EFFECTIVE DATE: This act is effective when it becomes law.

H1343e2-SMSQ-CSSQ-60

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

HOUSE BILL 2120*

Short Title:	Strengthen LOC Oversight Role.	(Public)
Sponsors:	Representatives Insko, Steen, Farmer-Butterfield, Parmon (Primary Sponsors); Alexander, Barnhart, Earle, England, Justice, Coleman, Goodwin, Jones, Lucas, Luebke, McLawhorn, Underhill, and Weiss.	
Referred to:	Health.	

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN THE OVERSIGHT ROLE OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES; TO REPEAL THE LEGISLATIVE STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES; TO DIRECT THE OVERSIGHT COMMITTEE TO STUDY CERTAIN ISSUES; AND TO MAKE A RECOMMENDATION REGARDING INCREASING HEALTH CARE COVERAGE TO INCLUDE MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 27 of Chapter 120 is amended by adding a new section to read:

"**§ 120-244. Committee authority.**

The Committee may obtain information and data from all State officers, agents, agencies, and departments, while in discharge of its duties, under G.S. 120-19, as if it were a committee of the General Assembly. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a committee of the General Assembly. Any cost of providing information to the Committee not covered by G.S. 120-19.3 may be reimbursed by the Committee from funds appropriated to it for its continuing study."

SECTION 2. Article 23 of Chapter 120 of the General Statutes is repealed.

SECTION 3. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall study the

following issues and report its findings and recommendations to the 2007 Regular Session of the 2007 General Assembly:

(1) Mechanisms to allow area authorities and county programs to purchase bed days from the State psychiatric hospitals. The LOC shall consider options for holding area authorities and county programs accountable for their use of State psychiatric institutions, provide incentives to increase community capacity, and options for ensuring the State institutions have a sufficient funding stream to ensure quality care to patients and a stable and well-qualified workforce.

(2) Whether implementation of a Medicaid 1915(b) waiver on a statewide or expanded local basis would strengthen the ability of area authorities and county programs to manage the mental health, developmental disabilities, and substance abuse system. As part of the study, the LOC shall examine the impact of the waiver on Piedmont Behavioral Health's ability to implement its management functions including utilization management for Medicaid services, consumer satisfaction, provider monitoring, use of best practices, and any other matters the LOC determines are relevant. If the LOC determines that a Medicaid 1915(b) waiver would improve the management capacity of area authorities and county programs, it shall also examine whether it would be more appropriate to seek a statewide waiver or whether it would be both possible and advisable for additional area authorities and county programs to seek individual waivers.

(3) Whether G.S. 122C-147.1 should be amended to modify or repeal the provisions that place funds appropriated by the General Assembly into broad age and disability categories.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 2120*
PROPOSED SENATE COMMITTEE SUBSTITUTE H2120-CSSQ-62 [v.1]

6/12/2006 1:38:50 PM

Short Title: Strengthen LOC Oversight Role. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN THE OVERSIGHT ROLE OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES; TO REPEAL THE LEGISLATIVE STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES; TO DIRECT THE OVERSIGHT COMMITTEE TO STUDY CERTAIN ISSUES; AND TO MAKE A RECOMMENDATION REGARDING INCREASING HEALTH CARE COVERAGE TO INCLUDE MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 27 of Chapter 120 is amended by adding a new section to read:

"**§ 120-244. Committee authority.**

The Committee may obtain information and data from all State officers, agents, agencies, and departments, while in discharge of its duties, under G.S. 120-19, as if it were a committee of the General Assembly. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a committee of the General Assembly. Any cost of providing information to the Committee not covered by G.S. 120-19.3 may be reimbursed by the Committee from funds appropriated to it for its continuing study."

SECTION 2. Article 23 of Chapter 120 of the General Statutes is repealed.

SECTION 3. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall study the following issues and report its findings and recommendations to the 2007 Regular Session of the 2007 General Assembly:

(1) Mechanisms to allow area authorities and county programs to purchase bed days from the State psychiatric hospitals. The LOC shall consider options for holding area authorities and county programs accountable for their use of State psychiatric institutions, provide incentives to increase community capacity, and options for ensuring the State institutions have a sufficient funding stream to ensure quality care to patients and a stable and well-qualified workforce.

(2) Whether implementation of a Medicaid 1915(b) waiver on a statewide or expanded local basis would strengthen the ability of area authorities and county programs to manage the mental health, developmental disabilities, and substance abuse system. As part of the study, the LOC shall examine the impact of the waiver on Piedmont Behavioral Health's ability to implement its management functions including utilization management for Medicaid services, consumer satisfaction, provider monitoring, use of best practices, and any other matters the LOC determines are relevant. If the LOC determines that a Medicaid 1915(b) waiver would improve the management capacity of area authorities and county programs, it shall also examine whether it would be more appropriate to seek a statewide waiver or whether it would be both possible and advisable for additional area authorities and county programs to seek individual waivers.

(3) Whether G.S. 122C-147.1 should be amended to modify or repeal the provisions that place funds appropriated by the General Assembly into broad age and disability categories.

SECTION 4. The Joint Legislative Corrections, Crime Control and Juvenile Justice Oversight Committee and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall study drug treatment courts in North Carolina. The study shall include the following issues in relation to drug treatment courts:

(1) Funding mechanisms;

(2) Target populations;

(3) Interagency collaboration at the State and local levels; and

(4) Any other matter that the Commissions deem appropriate or necessary to provide proper information to the General Assembly on the subject of the study.

The Commissions may report their findings and recommendations to the 2007 Regular Session of the 2007 General Assembly.

SECTION 5. The act is effective when it becomes law.

HOUSE BILL 2120:
Strengthen LOC Oversight Role

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 13, 2006
Introduced by:	Reps. Insko, Steen, Farmer-Butterfield, Parmon	**Summary by:**	Shawn Parker Legislative Analyst
Version:	PCS to First Edition H2120-CSSQ-62		

SUMMARY: House Bill 2120 grants the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) the authority consistent with other oversight committees, abolishes the Legislative Study Commission on Mental health, Developmental Disabilities, and Substance Abuse Services, and directs the LOC to study certain issues.

The Senate Proposed Committee Substitute directs the LOC and the Joint Legislative Corrections, Crime Control and Juvenile Justice Oversight Committee to study drug treatment courts in North Carolina.

Effective when it becomes law.

BILL ANALYSIS: House Bill 2120 amends Article 27 of Chapter 120 of the North Carolina General Statutes to provide the LOC with the ability to obtain information and data from all State officers, agents, agencies, and departments, while in discharge of its duties. This provision is consistent with other legislative oversight committees. The bill also repeals Article 23 of Chapter 120, abolishing the Legislative Study Commission on Mental health, Developmental Disabilities, and Substance Abuse Services. The bill further directs the LOC to study the following:

- Mechanisms to allow LMEs to purchase bed days from the State psychiatric hospitals;
- Impacts of expanding a Medicaid 1915(b) waiver to a State-wide basis;
- Impacts of consolidating age and disability funding categories.

The PCS to House Bill 2120 further directs the LOC and the Joint Legislative Corrections, Crime Control and Juvenile Justice Oversight Committee to study funding mechanisms, target populations, and interagency collaboration as they relate to drug treatment courts in North Carolina.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This is a recommendation from the Joint Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

H2120e1-SMSQ-CSSQ-62

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1487*

Short Title:	Dental Hygiene Law Changes.	(Public)
Sponsors:	Senators Nesbitt, Purcell, Stevens, Webster; Bland, Dorsett, Hartsell, Kerr, and Snow.	
Referred to:	Health Care.	

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS TO ACCEPT, IN ADDITION TO EXAMINATIONS CONDUCTED BY THE BOARD, THE RESULTS OF OTHER BOARD-APPROVED REGIONAL OR NATIONAL INDEPENDENT THIRD-PARTY CLINICAL EXAMINATIONS OF APPLICANTS SEEKING A LICENSE TO PRACTICE AS A DENTAL HYGIENIST, AND AUTHORIZING THE BOARD TO CHARGE THE ACTUAL COST OF THE THIRD-PARTY TESTING SERVICE, AS RECOMMENDED BY THE JOINT LEGISLATIVE ADMINISTRATIVE PROCEDURE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-223(a) reads as rewritten:

"(a) The Board is authorized and empowered to:

(1) Conduct examinations for licensure,

(2) Issue licenses and provisional licenses,

(3) Issue annual renewal certificates, ~~and~~

(4) Renew expired ~~licenses.~~ licenses, and

(5) Contract with a regional or national testing agency to conduct clinical examinations. Prior to entering a contract with a regional or national testing agency, the Board shall evaluate the agency based on the following criteria:

a. The number of states that recognize the results of the testing agency's examination.

b. The cost to the applicant of the examination.

c. How long the testing agency has been conducting examinations.

d. Whether the examination includes procedures performed on human subjects as part of the assessment of restorative clinical competencies."

SECTION 2. G.S. 90-224 reads as rewritten:

"**§ 90-224. Examination.**

(a) The applicant for licensure must be of good moral character, have graduated from an accredited high school or hold a high school equivalency certificate duly issued by a governmental agency or unit authorized to issue the same, and be a graduate of a program of dental hygiene in a school or college approved by the Board.

(b) The Board shall have the authority to establish in its rules and regulations:

(1) The form of application;

(2) The time and place of examination;

(3) The type of examination;

(4) The qualifications for passing the examination.

(b1) The Board also may grant a license to an applicant who is found to have passed an examination given by a Board-approved regional or national dental hygiene testing agency, provided that the Board deems the regional or national examination to be substantially equivalent to or an improvement upon the examination given by the Board, and the applicant meets the other qualifications set forth in this Article.

(c) The Department of Justice may provide a criminal record check to the Board for a person who has applied for a new or renewal license through the Board. The Board shall provide to the Department of Justice, along with the request, the fingerprints of the applicant, any additional information required by the Department of Justice, and a form signed by the applicant consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Board shall keep all information pursuant to this subsection privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes.

The Department of Justice may charge each applicant a fee for conducting the checks of criminal history records authorized by this subsection."

SECTION 3. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

(a) In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules not exceeding the following:

(1) Each applicant for examination $350.00

(2) Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist 250.00

(3) Each restoration of license 150.00
(4) Each provisional license 150.00
(5) Each certificate of license to a resident dental hygienist desiring to change to another state or territory 50.00
(6) Annual fee to be paid upon license renewal to assist in funding programs for impaired dental hygienists 80.00
(7) Each license by credentials ..... 1,500.

(b) In all instances where the Board uses the services of a regional or national testing agency for preparation, administration, or grading of examinations, the Board may require applicants to pay the actual cost of the testing agency in lieu of the fee authorized in subdivision (a)(1) of this section.

(c) In no event may the annual fee imposed on dental hygienists to fund the impaired dental hygienists program exceed the annual fee imposed on dentists to fund the impaired dentist program. All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

SECTION 4. The North Carolina State Board of Dental Examiners shall continue to conduct clinical examinations for applicants seeking a license to practice dental hygiene until at least September 30, 2007. No applicant for a dental hygiene license shall be required to take a Board-approved regional or national independent third-party clinical examination prior to September 30, 2007.

SECTION 5. Notwithstanding any provision to the contrary, the North Carolina State Board of Dental Examiners may accept any application for the dental hygiene clinical examination to be conducted on June 8, 2006, if the application was received on or before March 31, 2006.

SECTION 6. This act becomes effective July 1, 2006.

SENATE BILL 1487:
Dental Hygiene Law Changes

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 9, 2006
Introduced by:	Sen. Nesbitt	**Summary by:**	Shawn Parker Legislative Analyst
Version:	First Edition		

SUMMARY: Senate Bill 1487 would authorize the State Board of Dental Examiners to accept the results of Board-approved regional or national independent third party clinical examinations for applicants seeking a dental hygiene license. The bill also authorizes the Board to charge applicants the actual cost of the third-party testing service. This bill is a recommendation of the Joint Legislative Administrative Procedure Oversight Committee.

CURRENT LAW: The North Carolina Dental Hygiene Act governs the licensure of dental hygienist. The Act authorizes the Board to conduct examinations for licensure and to establish rules for:

- The form of application;
- The time and place of examination;
- The type of examination; and
- The qualifications for passing the examination.

The Board does not have specific authorization to contract with third parties to provide examinations. Session Law 2005-366 amended the Dental Practice Act to authorize the Board to use outside testing agencies for the examination of dentists. How ever, no such statutory amendment was made to the Dental Hygiene Act.

BILL ANALYSIS: The bill would authorize the Board to contract with third-party testing agencies to conduct clinical exams for dental hygiene applicants. Its sets a number of criteria to be considered by the Board before entering such a contract, including:

- The number of states that recognize the test
- The cost of the examination
- How long the testing agency had been conducting exams
- Whether the exam includes procedures performed on human subjects

The Board may require applicants to pay the actual cost of the third party exam.

The bill also directs the Board to continue to conduct its own exams until at least September 30, 2007. The Board may accept applications for this year's exam if they were received on or before March 31, 2006.

EFFECTIVE DATE: This act becomes effective July 1, 2006.

Karen Cochrane-Brown substantially contributed to this summary.

S1487e1-SMSQ

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1487*

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

S1487-ASQ-30 [v.1]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Senator Nesbitt

moves to amend the bill on page 1, line 27, by rewriting the line to read:
" human subjects as part of the assessment of clinical".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

Health Care Committee — **June 14, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lea Hodges	Kennedy Covington
Flo Stein	DMH/DD/SAS
Ridgway & Ellis	Ridgway & Ellis & Associates
Bill Rowe	NC Justice Center
Willy Rowe	Raleigh

VISITOR REGISTRATION SHEET

Health Care Committee — **June 14, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	Wake Forest University
Guy Palmes MD	NC Psychiatric Association
Amy Jo Horne	NCMS
Robin Huffman	NC Psychiatric Assoc
Jami Fitzgerald	NCFPC
Gerald Cowan	NCHBA
Jana Johnson	Tobacco Prevention + Control Branch, NC DHHS
Sally Alexander Maher	Tobacco Prevent + Control Branch NCDPH DHHS
Kristen Shipherd	NC Medical Society
Bryan D. Spader, MD	East pointe MHC Kinston, NC
Cindy Wiggins	Govs office
Tracy Kimbrell	Parker Poe

VISITOR REGISTRATION SHEET

Health Care Committee — **June 14, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible] Potter	NCOS & NCPTA
Bobby D White	NC Dental Board
Colleen Kochanek	NCSHA / NCCEP
Brian Lewis	Covenant w/ NC's Children
Mary Beth Wims	NC Prevention Partners
Elizabeth Outten	American Cancer Society
Mary Wilder	Amer. Cancer Society
Betsy Vetter	American Heart Association
Pam Seamans	NC Alliance for Health
John Thompson	American Cancer Society
Susan King Cope	American Lung Association of NC
Dave Horn	SA

VISITOR REGISTRATION SHEET

Health Care Committee — **June 14, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sloan Garner	American Heart Association
Penn Kath	NCGA Staff
Marcus Dawe	NC State Health Plan
Lynette Zor	HHS
Jeff Wolfe	Daily Bulletin
Charlotte Graham	Am. Heart Assoc.
Dan Albright MD	N.C. Medical Society
Allison Clegg	NCMS
Megan Glazier	Rep. Glazier
Deborah A. Parker	NCCCS
John Reynolds	N.C. Med. Society
Dr. Dan Johnston	Wake Forest University NC Psychiatric Association

AGENDA

SENATE HEALTH CARE COMMITTEE
June 21, 2006, at 3:30 P.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bills to be Considered

- HB 1502 School Children Health Act — Rep. Martin
- HB 2077 Strengthen MH/DD/SA Private Providers — Rep. Insko
- SB1275 Health Care Personnel Registry Expansion — Sen. Dannelly
- SB1280 DHHS Evaluate Telemonitoring — Sen. Dannelly

IV Other Business

V. Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday June 21, 2006
3:30 P.M.
Room 643, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 3:30 P.M. on Wednesday, June 21, 2006, in Room 643 of the Legislative Office Building, with thirteen members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell asked Senator Dannelly to bring his bill, SB1275, *Health Care Personnel Registry Expansion* before the committee. He explained the provisions of the bill and noted that there is a Proposed Committee Substitute for this bill. Senator Bingham moved that the PCS be adopted for purposes of discussion. Senator Lucas asked the number of positions funded under the terms of this bill. Senator Dannelly responded that there would be 18 investigators, 3 regional supervisor investigators, and 6 administrative support positions. Senator Dorsett moved for a favorable report, and the motion carried. The bill will be referred to the Appropriations Committee.

Senator Dannelly presented his bill, SB1280, *DHHS Evaluate Telemonitoring.* He asked that a PCS for this bill be approved for discussion, and the motion passed. Senator Dorsett asked why reimbursement is limited to home care agencies and not to others who might provide the same services. Dr. Allen Dobson, Director of Medical Assistance commented that there already are several pilot programs various other agencies and providers, who are being paid. Mr. Tim Rogers, Executive Director of Home and Hospice Care of North Carolina, pointed out that many home health agencies have already invested in very expensive equipment in order to reduce patient re-hospitalization. Senator Dorsett put forth an amendment which would provide remuneration for home care agencies and other providers. The amendment passed and will be rolled into a new PCS for this bill. Senator Nesbitt moved for a favorable report on the bill as amended, and it passed.

Representative Grier Martin explained his bill, HB 1502, *School Children Health Act.* Senator Hartsell proposed an amendment which would eliminate "preparatory language which could be used by creative attorneys in situations which could serve as an evidentiary basis for potential liability". The amendment was adopted. Senator Purcell submitted an amendment which changed dates in three places; and this amendment passed. He submitted another amendment, "nothing in this act shall be construed to create a private cause of action against any local board of education, its agents, or its employees". This also was adopted by the committee. Two representatives of the Treated Wood Council spoke against the bill. Dr. Luanne Williams, State Toxicologist spoke in favor of the bill, as did Dr. Cathy Shea, representing the North Carolina Pediatric Society. Vote on this bill was postponed due to lack of time.

HB2077, *Strengthen MH/DD/LS Private Providers* was not heard.

The meeting adjourned at 4:50 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 CARE COMMITTEE REPORT

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

Thursday, June 22, 2006

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

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

S.B. **1275** Health Care Personnel Registry Expansion.

Draft Number:	PCS55509
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **1280** DHHS Evaluate Telemonitoring.

Draft Number:	PCS15417
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1502

Committee Substitute Favorable 5/23/05

Short Title: Schoolchildren's Health Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO ENACT THE SCHOOLCHILDREN'S HEALTH ACT OF 2005.

Whereas, when school is in session, children spend 30% to 50% of their time at school; and

Whereas, it is incumbent upon State government to address public health and environmental issues in the classroom and on school grounds in order to protect the health of school-age children; and

Whereas, inexpensive and easy measures can be taken to provide a healthier learning environment for our children, and, in some instances, these measures actually offer a school district cost savings; and

Whereas, on March 4, 2004, a stakeholders group consisting of the Department of Public Instruction, the Department of Agriculture and Consumer Services, the North Carolina Cooperative Extension Service, the Agricultural Resources Center, the North Carolina Parent Teacher's Association, the N.C. Pest Control Association, The North Carolina State School Boards Association, Inc., and other entities signed a memorandum of understanding establishing their support for Integrated Pest Management (IPM) and creating a model school IPM policy; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act may be cited as the Schoolchildren's Health Act of 2005.

SECTION 2. The General Assembly makes the following findings:

(a) Arsenic-Treated Wood. –

(1) Effective 2004, arsenic-treated wood for residential uses has been removed from the marketplace under a voluntary agreement between the United States Environmental Protection Agency and the industry. Since this is a voluntary agreement, only a State ban will ensure that arsenic-treated wood is not used on school grounds in the future.

(2) Additionally, backstock arsenic-treated wood is still on the market in some places.

(3) A ban of CCA (chromated copper arsenate) treated wood for use in public schools is a reasonable safeguard measure.

(b) Mercury. –

(1) Mercury is a potent brain toxicant, and children, whose brains are still developing, are most vulnerable to its effects.

(2) Once introduced into the human body, mercury interferes with brain development and can lead to a number of developmental problems, including delayed language acquisition, impaired memory, and learning disabilities.

(c) Diesel Exhaust Fumes. –

(1) Because children's respiratory systems are still developing and they breathe more rapidly, children are more susceptible to air pollution than the average adult is.

(2) Diesel exhaust poses a particular risk to children, because it contains significant levels of small particles, known as fine particulate matter. This particulate matter is so fine that it can pass through the nose and throat and lodge in the lungs, possibly causing long-term adverse health effects.

(3) Particulate matter from diesel exhaust is associated with asthma and has been found to increase the risk of lung disease and heart disease. Additionally, it can bind to pollen in the air, further exacerbating allergies and asthma. Diesel exhaust is also known to contain several human carcinogens.

(4) School bus idling and bus queuing (nose-to-tail lineup of buses) dramatically increase the concentrations of detrimental particulate pollution inside school buses.

(d) Pesticides. –

(1) Because children's bodies are still developing, exposure to pesticides can have serious impacts on their long-term health.

(2) Schools may subject themselves to liability for immediate injuries to students, faculty, or other staff resulting from improper management of toxic chemicals such as pesticides.

(3) Schools can reduce or even eliminate the risks of pesticides by using simple, low-cost methods, such as Integrated Pest Management (IPM).

(4) With proper training, planning, and effective communication among affected parties, IPM can prevent pest problems, reduce the need for pesticide applications, and greatly improve the quality of the school environment.

(e) Mold and Mildew. –

(1) Mold and mildew problems occur in schools when moisture gets into the structure, thereby creating a friendly environment for excessive mold and mildew growth.

(2) Parents and school officials have become more aware of the health risks of mold, such as allergic reactions in children and adults, as the

public has become more aware of the problems associated with certain molds.

SECTION 3. G.S. 115C-12 is amended by adding a new subdivision to read:

"(33) Duty to Protect the Health of School-Age Children From Toxicants at School. – The State Board shall address public health and environmental issues in the classroom and on school grounds by doing all of the following:

a. Develop guidelines for sealing existing arsenic-treated wood in playground equipment or establish a time line for removing existing arsenic-treated wood on playgrounds and testing the soil on school grounds for contamination caused by the leaching of arsenic-treated wood in other areas where children may be at particularly high risk of exposure.

b. Establish guidelines to reduce students' exposure to diesel emissions that can occur as a result of unnecessary school bus idling, nose-to-tail parking, and inefficient route assignments.

c. Study methods for mold and mildew prevention and mitigation and incorporate recommendations into the public school facilities guidelines as needed.

d. Establish guidelines for Integrated Pest Management consistent with the policy of The North Carolina School Boards Association, Inc., as published in 2004. These guidelines may be updated as needed to reflect changes in technology.

e. Establish guidelines for notification of students' parents, guardians, or custodians as well as school staff of pesticide use on school grounds."

SECTION 4. G.S. 115C-47 is amended by adding four new subdivisions to read:

"(45) To Address the Use of Pesticides in Schools. – Local boards of education shall adopt policies that address the use of pesticides in schools. These policies shall:

a. Require the principal or the principal's designee to annually notify the students' parents, guardians, or custodians as well as school staff of the schedule of pesticide use on school property and their right to request notification. Such notification shall be made, to the extent possible, at least 72 hours in advance of nonscheduled pesticide use on school property. The notification requirements under this subdivision do not apply to the application of the following types of pesticide products: antimicrobial cleansers, disinfectants, self-contained baits and crack-and-crevice treatments, and any pesticide products classified by the United States Environmental Protection Agency as belonging to the U.S.E.P.A. Toxicity Class IV, "relatively nontoxic" (no signal word required on the product's

label). Nothing in this sub-subdivision shall be construed to create a private cause of action against any local board of education, its agents, or its employees.

b. Require the use of Integrated Pest Management. As used in this sub-subdivision, "Integrated Pest Management" or "IPM" means the comprehensive approach to pest management that combines biological, physical, chemical, and cultural tactics as well as effective, economic, environmentally sound, and socially acceptable methods to prevent and solve pest problems that emphasizes pest prevention and provides a decision-making process for determining if, when, and where pest suppression is needed and what control tactics and methods are appropriate.

(46) To Address Arsenic-Treated Wood in the Classroom and on School Grounds. – Local boards of education shall prohibit the purchase or acceptance of chromated copper arsenate-treated wood for future use on school grounds. Local boards of education shall seal existing arsenic-treated wood in playground equipment or establish a time line for removing existing arsenic-treated wood on playgrounds, according to the guidelines established under G.S. 115C-12(33). Local boards of education are encouraged to test the soil on school grounds for contamination caused by the leaching of arsenic-treated wood.

(47) To Address Mercury in the Classroom and on School Grounds. – Local boards of education are encouraged to remove and properly dispose of all bulk elemental mercury, chemical mercury, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers. Local boards of education shall prohibit the future use of bulk elemental mercury, chemical mercury compounds, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers.

(48) To Address Exposure to Diesel Exhaust Fumes. – Local boards of education shall adopt policies and procedures to reduce students' exposure to diesel emissions."

SECTION 5. G.S. 115C-47(45)b., as enacted by Section 4 of this act, becomes effective October 1, 2010. The remainder of this act becomes effective October 1, 2005.

HOUSE BILL 1502:
Schoolchildren's Health Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 20, 2006
Introduced by:	Reps. Martin, McLawhorn, Lucas	**Summary by:**	Sara Kamprath
Version:	Second Edition		Committee Staff

SUMMARY: House Bill 1502 directs the State Board of Education to protect school-age children from toxicants by addressing certain public health and environmental issues in classrooms and on school grounds. The bill also directs local boards of education to adopt policies and take steps to carry out the guidelines developed by the State Board of Education.

BILL ANALYSIS: Section 1 provides that the bill may be cited as the Schoolchildren's Health Act of 2005.

Section 2 of the bill provides the findings of the General Assembly on the serious health impacts of arsenic-treated wood, mercury, diesel exhaust fumes, pesticides and mold and mildew on young children.

Section 3 of the bill directs the State Board of Education to establish guidelines to address health and environmental issues related to:

- Sealing and removing arsenic-treated wood on playground equipment
- Reducing student exposure to diesel emissions
- Implementing Integrated Pest Management and procedures to notify parents, guardians and staff of pesticide use on school grounds

The State Board shall also study methods to prevent and mitigate mold and mildew and incorporate the recommendations into the public school facilities guidelines.

The bill adds language directing the State Board to develop guidelines for testing the soil on school grounds for contamination from leaching of arsenic-treated wood in other areas where children may be at high risk for exposure.

Section 4 of the bill adds four new duties for local school boards. The new duties address (i) giving parents and staff advance notification of pesticide application, (ii) banning future use of arsenic-treated wood in the classroom and school grounds, (iii) banning elemental mercury or chemical mercury compounds in the classroom and on school grounds, and (iv) reducing student exposure to exhaust fumes.

The bill also adds language that nothing in G.S. 115C-47 (45)a. shall create a private cause of action against any local board of education, its agents, or employees.

EFFECTIVE DATE: G.S. 115C-47(45)b. in Section 4 of the bill becomes effective October 1, 2010. The remainder of the bill becomes effective October 1, 2005.

BACKGROUND:

Arsenic-Treated Wood: Chromated copper arsenate (CCA) is a chemical wood preservative containing chromium, copper and arsenic that is used in pressure treated wood to prevent rotting. The US Environmental Protection Agency (EPA) reached an agreement with the manufacturers of wood preservative products to voluntarily phase out the use of CCA-treated wood. Starting in 2004, CCA-treated wood was no longer to be used in residential settings.

The EPA and the Consumer Product Safety Commission are currently conducting a two-year study of the effectiveness of sealants in preventing leaching of arsenic from CCA-treated wood. The study will end in August 2005 and a final report is expected at the end of the year.

Diesel Exhaust Fumes: In January 2001, the EPA adopted the Clean Diesel Trucks and Buses Rule that has more stringent standards for new diesel engines and fuels. Beginning in 2006, heavy-duty trucks and buses will be required to phase-in the use of lower sulfur fuels. These fuels will enable the effective use of modern-pollution control technology in new diesel engines. The new diesel engines will be phased-in beginning with the 2007 model year.

Pesticides: A model policy for Integrated Pest Management (IPM) was created in 2004 by the various stakeholders listed in the bill and is available to local school systems as a guide for developing their own policy.

Mold and Mildew: The Occupational and Environmental Epidemiology Branch (OEEB) of the Department of Health and Human Services has been providing local school systems with information, guidance and consultative services on indoor environmental quality since the 1980s. Recently, more and more schools have had to deal with mold contamination problems in their buildings. OEEB has personnel that can consult with school systems and conduct on-site evaluations.

CURRENT LAW:

§ 115C-524. Repair of school property; use of buildings for other than school purposes.

.....

(b) It shall be the duty of local boards of education and tax-levying authorities, in order to safeguard the investment made in public schools, to keep all school buildings in good repair to the end that all public school property shall be taken care of and be at all times in proper condition for use. It shall be the duty of all principals, teachers, and janitors to report to their respective boards of education immediately any unsanitary condition, damage to school property, or needed repair. All principals, teachers, and janitors shall be held responsible for the safekeeping of the buildings during the school session and all breakage and damage shall be repaired by those responsible for same, and where any principal or teacher shall permit damage to the public school buildings by lack of proper discipline of pupils, such principal or teacher shall be held responsible for such damage: Provided, principals and teachers shall not be held responsible for damage that they could not have prevented by reasonable supervision in the performance of their duties.

.....

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 2

H. B. No. 1502 DATE 6/21/06

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) Pierce
Sen.)

moves to amend the bill on page 4, line(s) 1-3

( ) WHICH CHANGES THE TITLE

by rewriting those lines to read:

" label)." ;

and on page 4, lines 32-33, by adding between the lines a new section to read:

"SECTION 5. Nothing in this act shall be construed to create a private cause of action against any local board of education, its agents, or its employees." ;

and by renumbering the remaining section accordingly.

SIGNED William R Pierce

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1502

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

H1502-ARJ-9 [v.1]

HB 1502

Date _____,2006

Comm. Sub. [NO]
Amends Title [YES]
Second Edition

Senator _____

moves to amend the bill on page 1, line 2; page 1, line 20; and page 4, line 35, by deleting "2005" and substituting "2006".;
and on page 4, line 34 by deleting "2010" and substituting "2011".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HB 1502

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1502

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

H1502-ARJ-8 [v.1]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Senator _____

moves to amend the bill on page 1, line 3, through page 3, line 2, by deleting those lines;
and by renumbering the remaining sections accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 2077*
Committee Substitute Favorable 6/5/06

Short Title: Strengthen MH/DD/SA Private Providers. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO ASSIST PRIVATE PROVIDERS TO DELIVER MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY 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-3(14) reads as rewritten:

"**§ 122C-3. Definitions.**

As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. ~~When the services offered are provided to individuals who are mentally ill or developmentally disabled, these~~ These

services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. ~~When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more.~~ Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "State facility", which is a facility that is operated by the Secretary;

g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers."

SECTION 2. G.S. 122C-142(a) reads as rewritten:

"**§ 122C-142. Contract for services.**

(a) When the area authority contracts with persons for the provision of services, ~~the area authority~~ it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. However, an area authority or county program may amend the contract to comply with any court-imposed duty or responsibility. Terms of the standard contract shall require the area authority to monitor the contract to assure that rules and State statutes are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided, and the client outcomes. The Secretary may also monitor contracted services to assure that rules and State statutes are met."

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

HOUSE BILL 2077:
Strengthen MH/DD/SA Private Providers

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 20, 2006
Introduced by:	Reps. Insko, Alexander, Barnhart, Earle	**Summary by:**	Shawn Parker
Version:	Second Edition		Committee Counsel

SUMMARY: House Bill 2077 modifies the definition of licensable facility to remove the distinction between facilities offering services to the mentally ill, developmentally disabled, or substance abusers and requires area authorities to use a standard contract when contracting for the provision of service.

Effective when it becomes law.

BILL ANALYSIS: House Bill 2077 as recommended by the Joint Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, would adjust the definition of licensable facility in G.S. 122C-3(14) to make facility licensure requirements for outpatient substance abuse services consistent with the facility licensure requirements for outpatient mental health or developmental disability services. The bill also requires area authorities when contracting with persons for provisions of services, to use the standard contract adopted by the Secretary. The bill allows area authorities to amend the contract to comply with a court-imposed duty.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This bill was a recommendation of the Joint Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

H2077e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 2

SENATE BILL 1275*

Health Care Committee Substitute Adopted 6/22/06

Short Title: Health Care Personnel Registry Expansion. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE HEALTH CARE PERSONNEL REGISTRY BY AMENDING THE DEFINITIONS OF HEALTH CARE FACILITIES AND HEALTH CARE PERSONNEL, AND TO APPROPRIATE FUNDS TO THE DIVISION OF FACILITY SERVICES FOR STAFFING, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(8) Residential Facilities as defined in G.S. 122C-3(14)e.
(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(10) Licensable Facilities as defined in G.S. 122C-3(14)b.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
(12) Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.~~the following are considered to be "health care personnel":~~

~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~
~~(2) A nurse aide.~~
~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~

~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer at a health care facility or potential employer at a health care facility of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;
(2) The neglect involved in the original finding was a singular occurrence; and
(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2006-2007 fiscal year to be used to establish positions to handle increases in allegations and investigations.

SECTION 3. Section 1 of this act becomes effective October 1, 2006. Section 2 of this act becomes effective July 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1275*
PROPOSED COMMITTEE SUBSTITUTE S1275-PCS55509-RD-47

Short Title: Health Care Personnel Registry Expansion. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE HEALTH CARE PERSONNEL REGISTRY BY AMENDING THE DEFINITIONS OF HEALTH CARE FACILITIES AND HEALTH CARE PERSONNEL, AND TO APPROPRIATE FUNDS TO THE DIVISION OF FACILITY SERVICES FOR STAFFING, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(8) Residential Facilities as defined in G.S. 122C-3(14)e.
(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(10) Licensable Facilities as defined in G.S. 122C-3(14)b.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
(12) Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.~~the following are considered to be "health care personnel":~~

~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~
~~(2) A nurse aide.~~
~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~

~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer at a health care facility or potential employer at a health care facility of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;
(2) The neglect involved in the original finding was a singular occurrence; and
(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2006-2007 fiscal year to be used to establish positions to handle increases in allegations and investigations.

SECTION 3. Section 1 of this act becomes effective October 1, 2006. Section 2 of this act becomes effective July 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1275*

Short Title:	Health Care Personnel Registry Expansion.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE HEALTH CARE PERSONNEL REGISTRY BY AMENDING THE DEFINITIONS OF HEALTH CARE FACILITIES AND HEALTH CARE PERSONNEL, TO PROHIBIT THE EMPLOYMENT BY HEALTH CARE FACILITIES OF ANY PERSON WHO HAS A SUBSTANTIATED FINDING ON THE HEALTH CARE PERSONNEL REGISTRY, AND TO APPROPRIATE FUNDS TO THE DIVISION OF FACILITY SERVICES FOR STAFFING, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(8) Residential Facilities as defined in G.S. 122C-3(14)e.
(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(10) Licensable Facilities as defined in G.S. 122C-3(14)b.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
(12) Community Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.~~the following are considered to be "health care personnel":~~

~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~
~~(2) A nurse aide.~~

~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~

~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) A health care facility shall not employ any person for whom a substantiated finding has been entered on the Health Care Personnel Registry. Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2006-2007 fiscal year, to be used to establish positions to handle increases in allegations and investigations.

SECTION 3. Section 1 of this act becomes effective October 1, 2006. Section 2 of this act becomes effective July 1, 2006. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1275*
PROPOSED COMMITTEE SUBSTITUTE S1275-CSRD-47 [v.2]

6/20/2006 3:27:58 PM

Short Title: Health Care Personnel Registry Expansion. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE HEALTH CARE PERSONNEL REGISTRY BY AMENDING THE DEFINITIONS OF HEALTH CARE FACILITIES AND HEALTH CARE PERSONNEL, AND TO APPROPRIATE FUNDS TO THE DIVISION OF FACILITY SERVICES FOR STAFFING, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(8) Residential Facilities as defined in G.S. 122C-3(14)e.
(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(10) Licensable Facilities as defined in G.S. 122C-3(14)b.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
(12) Community Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.~~the following are considered to be "health care personnel":~~

~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~
~~(2) A nurse aide.~~
~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~

~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer at a health care facility or potential employer at a health care facility of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2006-2007 fiscal year, to be used to establish positions to handle increases in allegations and investigations.

SECTION 3. Section 1 of this act becomes effective October 1, 2006. Section 2 of this act becomes effective July 1, 2006. The remainder of this act is effective when it becomes law.

SENATE BILL 1275:
Health Care Personnel Registry Expansion

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 20, 2006
Introduced by:	Sen. Dannelly	**Summary by:**	Ben Popkin
Version:	PCS to First Edition S1275-CSRD		Committee Counsel

SUMMARY: Senate Bill 1275 would expand the definition of "health care facilities", expand the definition of "health care personnel", and include an appropriation of $1,700,000 for the 2006-2007 fiscal year for the establishment of positions to handle increases in allegations and investigations. This bill is a recommendation from the Study Commission on Aging. If this bill receives a favorable report, it has a serial referral to House Appropriations.

The Proposed Committee Substitute would remove a provision that prohibited health care facilities from employing persons for whom a substantiated finding had been entered on the registry. The PCS would also insert language specifying that the Department would be directed to provide information to employers or potential employers 'at a health care facility'.

[As introduced, this bill was identical to H2050, as introduced by Reps. Earle, Weiss, Bordsen, England, which is currently in House Aging .]

CURRENT LAW:

The Department of Health and Human Services maintains a Health Care Personnel Registry that contains the names of all health care personnel working in health care facilities that have been subject to findings, or have been accused of and an investigation has been required, for the following acts:

- Neglect or abuse of a resident in a health care facility or person to whom home care (G.S. 131E-136) or hospice services (G.S. 131E-201) are being provided.
- Misappropriation of the property of a resident in a health care facility or resident of a place where home care or hospice services are being provided.
- Misappropriation of the property of the health care facility.
- Diversion of drugs belonging to a health care facility or to a patient or client.
- Fraud against a health care facility or against a patient or client for whom the employee is providing services

Individuals subject to the provisions of the Health Care Personnel Registry are defined by statute. G.S. 131E-256(b) defines entities that are considered "health care facilities" and G.S. 131E-256(c) defines individuals that are considered "health care personnel."

BILL ANALYSIS:

Section 1 would rewrite G.S. 131E-256(b) to add the following facilities to the list of "health care facilities" that would be included in the Health Care Personnel Registry:

- Licensable Facilities (defined in G.S. 122C-3(14)b) which includes any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, including a "licensable facility", which provides services for one or more minors or for two or more adults, including day services offered to the same individual for a period of three hours or more during a

24-hour period, or residential services provided for 24 consecutive hours or more. When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities.

- Multiunit Assisted Housing with Services (G.S. 131DD-2).
- Community Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
- Agencies providing in-home aid services funded through the Home and Community Care Block Grant (G.S.143B-181.1(a) 11).

The bill would revise G.S. 131E-256(c) to amend the definition of "health care personnel" broadening it to include any unlicensed staff of a health care facility (defined in G.S. 131E-256(b)) that has direct access to residents, clients, or their property.

- Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact
  - with an individual
  - or an individuals property,

  when that individual is a resident or person to whom services are provided.

The current definition in the statutes primarily pertains to those aides providing hands-on care (i.e. adult care home personal aides that supervise or perform specific tasks, nurse aides, in-home aides, or in-home personal care aides who provide hands on services, and unlicensed assistant personnel who provide hands on care.)

Section 2 would appropriate $1,700,000 to the DHHS, Division of Facility Services for the 2006-2007 fiscal year to be used to establish positions to handle increases in allegations and investigations. (See related detail provided in the second paragraph of the background information, below.)

EFFECTIVE DATE:
Section 1 of Senate Bill 1275 would become effective October 1, 2006, Section 2 would become effective July 1, 2006, and the remainder of the bill would be effective when it becomes law.

BACKGROUND:
S.L. 2005-276, Section 10.40A(q) required the Department of Health and Human Services (DHHS) to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings, including unlicensed health care settings, that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. On January 18, 2006, DHHS presented to the Study Commission on Aging, a report that included the changes contained in this bill.

Additionally, DHHS believes that they will need additional staff resources to process the increased number of allegation reports as a result of the expansion, and to manage expansions that have occurred over the last five years. (The Department reports that in the last five years, allegations have increased 280% and there has been a 62% increase in cases needing investigations.) The Department estimated that it would need $1.7 million for: 18 investigator positions, 3 regional supervisor/investigator positions, and 6 administrative support positions.

Theresa Matula, staff to the House Aging Committee, substantially contributed to this summary.

S1275e1-SMRD-CSRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 3

SENATE BILL 1280*

Health Care Committee Substitute Adopted 6/22/06
House Committee Substitute Favorable 7/11/06

Short Title: DHHS Evaluate Telemon/Home Care Licenses. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO ESTABLISH A PILOT PROGRAM TO EVALUATE THE USE OF TELEMONITORING EQUIPMENT FOR HOME AND COMMUNITY BASED RECIPIENTS, AND TO PROHIBIT THE ISSUING OF LICENSES FOR HOME CARE AGENCIES FOR ONE YEAR.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall implement a pilot program to evaluate the use of telemonitoring equipment in home and community based services. As determined by the Division, the Department shall provide remuneration to home care agencies and other providers for participation in the pilot program. The pilot program shall be implemented by October 1, 2006, and shall evaluate the use of telemonitoring equipment as a tool to improve the health of home and community based recipients through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The evaluation must include a representative number of older adults. The Department shall report to the Study Commission on Aging by August 1, 2007. The report shall include findings and recommendations on the cost-effectiveness of telemonitoring and the benefits to individuals and health care providers.

SECTION 2. Beginning January 1, 2007, and for a period of one year thereafter, the Department of Health and Human Services shall not issue any licenses for new home care agencies that intend to offer in-home aide services. This shall not restrict the Department from issuing licenses to certified home health agencies that intend to offer in-home aide services or to agencies that need a new license for an existing home care agency being acquired. This will allow the Department the time necessary to implement newly adopted home care rules.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1280*
PROPOSED COMMITTEE SUBSTITUTE S1280-PCS15417-SQ-65

Short Title: Adult Day Licensure / DHHS Evaluate Telemon. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO ESTABLISH A PILOT PROGRAM TO EVALUATE THE USE OF TELEMONITORING EQUIPMENT FOR HOME AND COMMUNITY BASED RECIPIENTS, AND AN ACT TO EXCLUDE CERTAIN ADULT DAY CARE FACILITIES FROM REGISTRATION AND LICENSURE REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall implement a pilot program to evaluate the use of telemonitoring equipment in home and community based services. As determined by the Division, the Department shall provide remuneration to home care agencies and other providers for participation in the pilot program. The pilot program shall be implemented by October 1, 2006, and shall evaluate the use of telemonitoring equipment as a tool to improve the health of home and community based recipients through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The evaluation must include a representative number of older adults. The Department shall report to the Study Commission on Aging by August 1, 2007. The report shall include findings and recommendations on the cost-effectiveness of telemonitoring, and the benefits to individuals and healthcare providers.

SECTION 2. G.S. 131D-2(c) reads as rewritten:

"(c) The following are excluded from the provisions of this section and are not required to be registered or obtain licensure under this section:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;

(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.

(6) Adult day care programs certified under G.S. 131D-6 that have received a grant from The Duke Endowment to develop and demonstrate the incorporation of 24-hour-a-day respite care to adults needing assistance or supervision during the term of the grant; provided that the facilities in which this care is provided shall be inspected at least annually by the appropriate local official or local inspector as provided in G.S. 143-139(b) for compliance with all applicable provisions of the North Carolina State Building Code."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S 1

SENATE BILL 1280*

Short Title:	DHHS Evaluate Telemonitoring.	(Public)
Sponsors:	Senators Dannelly, Allran, Bingham, Malone; Dorsett, Jenkins, Lucas, and Rand.	
Referred to:	Health Care.	

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO EVALUATE THE USE OF TELEMONITORING EQUIPMENT, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall evaluate the use of telemonitoring equipment as a tool to improve the health of home-based individuals through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The evaluation must include a representative number of older adults. The Department shall report to the Study Commission on Aging by August 1, 2007. The report shall include findings and recommendations on the cost-effectiveness of telemonitoring and the benefits to individuals and healthcare providers.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 1280*
PROPOSED COMMITTEE SUBSTITUTE S1280-CSSQ-65 [v.1]

6/20/2006 4:55:58 PM

Short Title: Adult Day Licensure / DHHS Evaluate Telemon. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO ESTABLISH A PILOT PROGRAM TO EVALUATE THE USE OF TELEMONITORING EQUIPMENT FOR HOME AND COMMUNITY BASED RECIPIENTS, AND AN ACT TO EXCLUDE CERTAIN ADULT DAY CARE FACILITIES FROM REGISTRATION AND LICENSURE REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall implement a pilot program to evaluate the use of telemonitoring equipment in home and community based services. As determined by the Division, the Department shall provide remuneration to home care agencies for participation in the pilot program. The pilot program shall be implemented by October 1, 2006 and shall evaluate the use of telemonitoring equipment as a tool to improve the health of home and community based recipients through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The evaluation must include a representative number of older adults. The Department shall report to the Study Commission on Aging by August 1, 2007. The report shall include findings and recommendations on the cost-effectiveness of telemonitoring and the benefits to individuals and healthcare providers.

SECTION 2. G.S. 131D-2(c) reads as rewritten:

"(c) The following are excluded from the provisions of this section and are not required to be registered or obtain licensure under this section:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;

(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.

(6) Adult day care programs certified under G.S.131D-6 that have received a grant from The Duke Endowment to develop and demonstrate the incorporation of 24 hour a day respite care to adults needing assistance or supervision during the term of the grant; provided that the facilities in which this care is provided shall be inspected at least annually by the appropriate local official or local inspector as provided in G. S. 143-139(b) for compliance with all applicable provisions of the North Carolina State Building Code."

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

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 6-21-06

S. B. No. 1280 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
Sen.) Dorsett

moves to amend the bill on page 1, line 12

( ) WHICH CHANGES THE TITLE

by re-writing the line to read:

" the Division, the Department shall provide remuneration to home care agencies and other providers for ".

SIGNED Katie Dorsett

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

VISITOR REGISTRATION SHEET

SENATE COMMITTEE ON HEALTH CARE — **JUNE 21, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Ward	NC Sierra Club
Lynne Perrin	DMH - DHHS
WYATT McGHEE	Franklin Co. Solid Waste Task Force
Ashley Matlock	Low Wealth Schools Coalition
Tommy Stevens	NCPC
Joann Stevens	NC Wildlife Federation
Jim Stephenson	NC Coastal Federation
Emily Kirby	NC Conservation Network

VISITOR REGISTRATION SHEET

SENATE COMMITTEE ON HEALTH CARE — **JUNE 21, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Adam Pridemore	NCASA
Jack Wyatt	Womble
Jim Edgerton	AHIC
Michael Nelson	Conservation Council of NC
Tom Vaughn	AFC
Eve Vitagliano	League of Women Voters
Caroline Reinke	Action for Children
Brian Lewis	Covenant w/ NC's Children
Alan Keith	NCGA Intern
Brian Wright	Conservation Council
Peggy Mangum	

VISITOR REGISTRATION SHEET

SENATE COMMITTEE ON HEALTH CARE — **JUNE 21, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCATL
Chris Brown	NCFA
Kristin Kelly	gov. office
Nancy Wilson	SBE

VISITOR REGISTRATION SHEET

SENATE COMMITTEE ON HEALTH CARE — **JUNE 21, 2006**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Shaw	NC Pediatric Society
Fawn Pattison	Ag Resources Ctr.
MIKE LINKER	NC STATE UNIVERSITY
Tom Vitaglione	Advocates for Children
Katherine M Shea MD	NC Pediatric Society
Toxicologist Luanne Williams	NC Department of Health and Human Services
Rita Dagher	SBE
Erin Kinney	NC Conservation Network
Gentry McLellan	NC Conservation Network.
Steve Wall	DENR
Mari Lewis	DSIC
Gary Salamido	Self
John McMillan	Mary Fields

AGENDA

SENATE HEALTH CARE COMMITTEE
June 27, 2006, at 9:00 A.M.
Room 643, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bills to be Considered

- HB 2077 Strengthen MH/DD/SA Private Providers — Rep. Insko, Rep. Bordsen, Rep. Barnhart

IV. Other Business

V. Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday June 27, 2006
9:00 A.M.
Room 643, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 9:00 A.M. on Tuesday, June 27, 2006, in Room 643 of the Legislative Office Building, with nine members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Forrester moved that a Proposed Committee Substitute be adopted for discussion. Senator Purcell pointed out that items contained in the bill and in the PCS are resultant from suggestions made by the Mental Health committees; and that a great deal of discussion with the committee chairs and the DHHS Secretary and her staff, as well as public input, went into these provisions. Senator Purcell recognized Representative Verla Insko to present her bill, HB 2077, *Strengthen MH/DD/SA Private Providers* to the Committee. She pointed out and reviewed the major provisions and policy changes. Senator Forrester asked if there is a provision regarding board members who miss a specified number of meetings, and the reply was that there is no such provision, but if needed one could be added at a later time. He also asked if there is a grandfather provision for keeping staff when the bill takes effect January 1, 2007. Shawn Parker, Research, said that there is such a provision. Senator Dorsett asked who makes the appointments for the advisory groups. Michael Moseley, Director of DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services, stated that the local advisory board of the LMEs makes the appointments. Senator Malone stated a concern about a board member fulfilling a number of qualifications, and Representative Insko said that a provision could be inserted that a board member could fulfill no more that two qualifications. Senator Forrester asked about the 15 percent transfer clause, whether the money could be transferred from services to administration, and Representative Insko said that the bill states that it could not. Senator Nesbitt submitted an amendment which changed various effective dates in the bill to just one date, January 1, 2007. Senator Purcell moved for adoption of the amendment, and it passed. Senator Nesbitt submitted a second amendment relating to Senator Malone's concern that a board member could fulfill no more than one category, and that amendment passed also. Both amendments will be rolled into a committee substitute. Senator Malone moved that a committee substitute with both amendments included be passed. The motion carried

The meeting adjourned at 10:40 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 CARE COMMITTEE REPORT

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

Wednesday, June 28, 2006

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) **2077** Strengthen MH/DD/SA Private Providers.

Draft Number:	PCS60837
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 2077*

Committee Substitute Favorable 6/5/06

PROPOSED SENATE COMMITTEE SUBSTITUTE H2077-PCS60837-LN-79

Short Title: Mental Health Reform Changes. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES WITH RESPECT TO THE IMPLEMENTATION OF MENTAL HEALTH REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-142(a) reads as rewritten:

"**§ 122C-142. Contract for services.**

(a) When the area authority contracts with persons for the provision of services, ~~the area authority~~ it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. However, an area authority or county program may amend the contract to comply with any court-imposed duty or responsibility. Terms of the standard contract shall require the area authority to monitor the contract to assure that rules and State statutes are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided, and the client outcomes. The Secretary may also monitor contracted services to assure that rules and State statutes are met."

SECTION 2.(a) G.S. 122C-102 reads as rewritten:

"**§ 122C-102. State Plan for Mental Health, Developmental Disabilities, and Substance Abuse ~~Services.~~Services; system performance measures.**

(a) Purpose of State Plan. – The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and county programs over a three-year period of time and benchmarks for determining whether progress is being made towards

those goals. It shall also identify data that will be used to measure progress towards the specified goals. In order to increase the ability of the State, area authorities, county programs, private providers, and consumers to successfully implement the goals of the State Plan, the Department shall not adopt or implement policies that are inconsistent with the State Plan without first consulting with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Content of State Plan. – The State Plan shall include the following:

(1) Vision and mission of the State Mental Health, Developmental Disabilities, and Substance Abuse Services system.

~~(2) Organizational structure of the Department and the divisions of the Department responsible for managing and monitoring mental health, developmental disabilities, and substance abuse services.~~

(3) Protection of client rights and consumer involvement in planning and management of system services.

(4) Provision of services to targeted populations, including criteria for identifying targeted populations.

(5) Compliance with federal mandates in establishing service priorities in mental health, developmental disabilities, and substance abuse.

(6) Description of the core services that are available to all individuals in order to improve consumer access to mental health, developmental disabilities, and substance abuse services at the local level.

(7) Service standards for the mental health, developmental disabilities, and substance abuse services system.

(8) Implementation of the uniform portal process.

(9) Strategies and schedules for implementing the service plan, including consultation on Medicaid policy with area and county programs, qualified providers, and others as designated by the Secretary, intersystem collaboration, promotion of best practices, technical assistance, outcome-based monitoring, and evaluation.

(10) A plan for coordination of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services with the Medicaid State Plan, and NC Health Choice.

(11) A business plan to demonstrate efficient and effective resource management of the mental health, developmental disabilities, and substance abuse services system, including strategies for accountability for non-Medicaid and Medicaid services.

(12) Strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of State funding across county programs and area authorities by January 1, 2007, including methods to identify service gaps and to ensure equitable use of State funds to fill those gaps among all counties.

(c) State Performance Measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following

matters: access to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, on the State's progress in these performance areas."

SECTION 2.(b) The North Carolina Department of Health and Human Services (DHHS) shall review all State Plans for Mental Health, Developmental Disabilities, and Substance Abuse Services, implemented after July 1, 2001, and before the effective date of this act and produce a single document that contains a cumulative statement of all still applicable provisions of those Plans. This cumulative document shall constitute the State Plan until July 1, 2007.

DHHS and the Secretary shall also identify those provisions in G.S. 122C-112.1, prior State Plans, and directives or communications by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services that must be adopted as administrative rules in order to be enforceable and undertake to adopt those rules.

SECTION 3.(a) G.S. 122C-117(c) reads as rewritten:

"(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. ~~to each member of the board of county commissioners the quarterly report of the area authority.~~ The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners."

SECTION 3.(b) Article 23 of Chapter 153A of the General Statutes is amended by adding the following new section to read:

"**§ 153A-453. Quarterly reports by Mental Health, Developmental Disabilities, and Substance Abuse Services area authority or county program.**

Quarterly reports by the area director and finance officer of Mental Health, Developmental Disabilities, and Substance Abuse Services area authorities or county programs shall be submitted to the county finance officer as provided under G.S. 122C-117(c)."

SECTION 4.(a) G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

~~As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:~~The following definitions apply in this Chapter:

...

(20b) "Local management entity" or "LME" means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.

..."

SECTION 4.(b) G.S. 122C-111 reads as rewritten:

"**§ 122C-111. Administration.**

The Secretary shall administer and enforce the provisions of this Chapter and the rules of the Commission and shall operate State facilities. An area director or program director shall (i) manage the public mental health, developmental disabilities, and substance abuse system for ~~administer the programs of~~ the area authority or county ~~program, as applicable,~~ program according to the local business plan, and (ii) enforce applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area and county program directors and State facility directors shall provide for the coordination of public services between area authorities, county programs, and State facilities. The area authority or county program shall monitor the provision of mental health, developmental ~~disability,~~disabilities, and substance abuse services for compliance with the law, which monitoring and management shall not supersede or duplicate the regulatory authority or functions of agencies of the Department."

SECTION 4.(c) G.S. 122C-115.2(a) reads as rewritten:

"**§ 122C-115.2.** ~~Business~~ LME business plan required; content, process, certification.

(a) Every county, through an area authority or county program, shall provide for the development, review, and approval of ~~a~~ an LME business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services. ~~A~~ An LME business plan shall provide detailed information ~~on~~ regarding how the area authority or county program will meet State standards, laws, and rules for ensuring quality mental health, developmental disabilities, and substance abuse services, including outcome measures for evaluating program effectiveness. The business plan shall be in effect for at least three State fiscal years."

SECTION 4.(d) Article 4 of Chapter 122C is amended by adding a new section to read:

"**§ 122C-115.4. Functions of local management entities.**

(a) Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME include all of the following:

(1) Access for all citizens to the core services described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider endorsement, monitoring, technical assistance, capacity development, and quality control. An LME may remove a provider's endorsement if a provider fails to meet defined quality criteria or fails to provide required data to the LME.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services including the review and approval of the person centered plans for consumers who receive State-funded services. Concurrent review of person centered plans for all consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function includes the direct monitoring of the effectiveness of person centered plans. It also includes the initiation of and participation in the development of required modifications to the plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers, and review of consumer charts.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(c) Subject to all applicable State and federal laws and rules established by the Secretary, an area authority, or county program or consolidated human services agency may contract with a public or private entity for the implementation of LME functions articulated under subsection (b) of this section.

(d) Except as provided in G.S. 122C-142.1 and G.S. 122C-125, the Secretary may not remove from an LME any function enumerated under subsection (b) of this section unless all of the following applies:

(1) The LME fails during the previous three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).

(2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at

least six months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.

(3) If, after six months of receiving technical assistance from the Secretary, the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed.

(e) Notwithstanding subsection (d) of this section, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may temporarily remove an LME function after consultation with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(f) The Commission shall adopt rules regarding the following matters:

(1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.

(2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.

(3) The notice and procedural requirements for removing one or more LME functions under subsection (d) of this section."

SECTION 4.(e) G.S. 122C-118.1(a) reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties and serving a catchment area with a population of more than 500,000 may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, ~~equitable~~ representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include ~~an individual~~ two individuals with financial ~~expertise or a county finance officer,~~ expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or

without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~At least~~ Not more than fifty percent (50%) of the members of the area board shall represent the following:

(1) A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.

(2) A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.

(3) ~~A~~ At least one family member or ~~an~~ individual from a citizens' ~~organizations~~ organization composed primarily of consumers or their family members, representing the interests of individuals:

a. With mental illness; ~~and~~

b. In recovery from addiction; ~~and~~ or

c. With developmental disabilities.

(4) ~~Openly~~ At least one openly declared ~~consumers:~~consumer:

a. With mental illness; ~~and~~

b. With developmental ~~disabilities; and~~ disabilities; or

c. In recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than ~~one category~~ two categories of membership if the member has the qualifications or attributes of ~~more than one category~~ the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity. The terms of county commissioners on an area board are concurrent with their terms as county commissioners. The terms of the other members on the area board shall be for ~~four~~ three years, except that upon the initial formation of an area board ~~one-fourth~~ one-third shall be appointed for one year, ~~one-fourth~~ one-third for two years, ~~one-fourth for three years,~~ and all remaining members for ~~four~~ three years. Members ~~other than county commissioners~~ shall not be appointed for more than two consecutive terms. Board members serving as of July 1, 2006, may remain on the board for one additional term.

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 4.(f) G.S. 122C-115.1(g) reads as rewritten:

"(g) In a single-county program, an advisory committee shall be appointed by the board of county commissioners and shall report to the county manager. The appointments shall take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. ~~At least fifty percent (50%) of the~~ The membership shall conform to the requirements in ~~G.S. 122C-118.1(b)(1)-(4).~~ G.S. 122C-118.1. In a multicounty program,

the advisory committee shall be appointed in accordance with the terms of the interlocal agreement."

SECTION 4.(g) G.S. 122C-115.1(a) reads as rewritten:

"**§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.**

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. Except when specifically waived by the Secretary, the program director shall meet the following minimum qualifications:

a. Masters degree,

b. Related experience, and

c. Management experience.

(3) A targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program.

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. ~~At least fifty percent (50%) of the~~The membership shall conform to the requirements provided in ~~G.S. 122C-118.1(b)(1)-(4).~~G.S. 122C-118.1."

SECTION 4.(h) Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-120.1. Job classifications; director and finance officer.**

(a) The Office of State Personnel shall develop a job classification for director of an area authority or county program that reflects the skills required of an individual operating a local management entity. The Office of State Personnel shall also review the job classifications for area authority and county program finance officers to determine whether they reflect the skills necessary to manage the finances of a local management entity. The Commission shall adopt a job classification for director and any new or revised job classifications for finance officers no later than December 31, 2006.

(b) The job classifications developed under subsection (a) of this section shall apply to persons newly hired on or after January 1, 2007."

SECTION 4.(i) Effective January 1, 2007, G.S. 122C-115.1(a), as amended by Section 4(g) of this act, reads as rewritten:

"**§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.**

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. Except when specifically waived by the Secretary, the program director shall meet all the following minimum qualifications:

a. Masters ~~degree.~~degree.

b. Related ~~experience, and~~ experience.

c. Management experience.

d. Any other qualifications required under G.S. 122C-120.1.

(3) A targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program.

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the requirements provided in G.S. 122C-118.1."

SECTION 4.(j) Effective January 1, 2007, G.S. 122C-115.1(f) reads as rewritten:

"(f) In a single-county program, the program director shall be appointed by the county manager. In a multicounty program, the program director shall be appointed in accordance with the terms of the interlocal agreement.

Except when specifically waived by the Secretary, the program director in a single county program shall meet all the following minimum qualifications:

(1) Masters degree.

(2) Related experience.

(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1."

SECTION 4.(k) Effective January 1, 2007, G.S. 122C-121(d) reads as rewritten:

"(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:
(1) Masters ~~degree;~~degree.
(2) Related ~~experience; and~~ experience.
(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1."

SECTION 4.(l) G.S. 122C-141 is amended by adding two new subsections to read:

"(d) If two or more counties enter into an interlocal agreement under Article 20 of Chapter 160A of the General Statutes to be a public provider of mental health, developmental disabilities, or substance abuse services ("public provider"), before an LME may enter into a contract with the public provider, all of the following must apply:
(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Secretary. A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.
(2) The LME must adopt a conflict of interest policy that applies to all provider contracts.
(3) The interlocal agreement must provide that any liabilities of the public provider shall be paid from its unobligated surplus funds and that if those funds are not sufficient to satisfy the indebtedness, the remaining indebtedness shall be apportioned to the participating counties.

(d1) The Secretary shall ensure that there is fair competition among providers. The Department shall study the effect of subsection (d) of this section and shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by December 1, 2009."

SECTION 4.(m) G.S. 122C-112.1(a) reads as rewritten:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:
(1) Oversee development and implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.
(2) Enforce the provisions of this Chapter and the rules of the Commission and the Secretary.
(3) Establish a process and criteria for the submission, review, and approval or disapproval of LME business plans submitted by area authorities and ~~counties~~ county programs for the management ~~and provision~~ of mental health, developmental disabilities, and substance abuse services.

(4) Adopt rules specifying the content and format of LME business plans.

(5) Review LME business plans and, upon approval of the ~~business~~ plan, certify the submitting area authority or county program to ~~provide~~ manage the delivery of mental health, developmental disabilities, and substance abuse ~~services.~~services in the applicable catchment area.

(6) Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities, county programs, and all providers of public services with State and federal policy, law, and standards. ~~Procedures~~ The procedures shall include the development and use of critical performance measures and report cards for each area authority and county program.

(7) Conduct regularly scheduled monitoring and oversight of area authority, county programs, and all providers of public services. Monitoring and oversight shall ~~include~~ be used to assess compliance with the ~~program~~ LME business ~~plan,~~ plan and implementation of core ~~administrative functions, and fiscal and administrative practices and~~ LME functions. Monitoring shall also ~~address~~ include the examination of LME and provider performance on outcome ~~measures,~~ measures including adherence to best practices, the assessment of consumer satisfaction, and the review of client rights ~~complaints, and adherence to best practices.~~complaints.

(8) Make findings and recommendations based on information and data collected pursuant to subdivision (7) of this subsection and submit these findings and recommendations to the applicable area authority board, county program director, board of county commissioners, providers of public services, and to the Local Consumer Advocacy Office.

(9) ~~Assist~~ Provide ongoing and focused technical assistance to area authorities and county programs in the implementation of the LME functions and the establishment and operation of community-based programs. The technical assistance required under this subdivision includes, but is not limited to, the technical assistance required under G.S. 122C-115.4(d)(2). The Secretary shall include in the State Plan a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities and county programs in achieving these functions.

(10) Operate State facilities and adopt rules pertaining to their operation.

(11) Develop a unified system of services provided ~~in area, county, and~~ at the community level, by State facilities, and by providers enrolled or under a contract with the ~~State.~~State and an area authority or county program.

(12) Adopt rules governing the expenditure of all funds for mental health, developmental disabilities, and substance abuse programs and services.

(13) Adopt rules to implement the appeal procedure authorized by G.S. 122C-151.2.
(14) Adopt rules for the implementation of the uniform portal process.
(15) Except as provided in G.S. 122C-26(4), adopt rules establishing procedures for waiver of rules adopted by the Secretary under this Chapter.
(16) Notify the clerks of superior court of changes in the designation of State facility regions and of facilities designated under G.S. 122C-252.
(17) Promote public awareness and understanding of mental health, mental illness, developmental disabilities, and substance abuse.
(18) Administer and enforce rules that are conditions of participation for federal or State financial aid.
(19) Carry out G.S. 122C-361.
(20) Monitor the fiscal and administrative practices of area authorities and county programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance abuse services. The Secretary shall ensure maximum accountability by area authorities and county programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles.
(21) Provide technical assistance, including conflict resolution, to counties in the development and implementation of area authority and county program business plans and other matters, as requested by the county.
(22) Develop a methodology to be used for calculating county resources to reflect cash and in-kind contributions of the county.
(23) Adopt rules establishing program evaluation and management of mental health, developmental disabilities, and substance abuse services.
(24) Adopt rules regarding the requirements of the federal government for grants-in-aid for mental health, developmental disabilities, or substance abuse programs which may be made available to area authorities or county programs or the State. This section shall be liberally construed in order that the State and its citizens may benefit from the grants-in-aid.
(25) Adopt rules for determining minimally adequate services for purposes of G.S. 122C-124.1 and G.S. 122C-125.
(26) Establish a process for approving area authorities and county programs to provide services directly in accordance with G.S. 122C-141.
(27) Sponsor training opportunities in the fields of mental health, developmental disabilities, and substance abuse.

(28) Enforce the protection of the rights of clients served by State facilities, area authorities, county programs, and providers of public services.

(29) Adopt rules for the enforcement of the protection of the rights of clients being served by State facilities, area authorities, county programs, and providers of public services.

(30) Prior to requesting approval to close a State facility under G.S. 122C-181(b):

a. Notify the Joint Legislative Commission on Governmental Operations, the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and members of the General Assembly who represent catchment areas affected by the closure; and

b. Present a plan for the closure to the members of the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services for their review, advice, and recommendations. The plan shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the committees to which the plan is presented under this subdivision.

(31) Ensure that the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services is coordinated with the Medicaid State Plan and NC Health Choice.

(32) Implement standard forms, quality measures, contracts, processes, and procedures to be used by all area authorities and county programs with other public and private service providers. The Secretary shall consult with LMEs, CFACs, counties, and qualified providers regarding the development of any forms, processes, and procedures required under this subdivision. Any document, process, or procedure developed under this subdivision shall place an obligation upon providers to transmit to LMEs timely client information and outcome data. The Secretary shall also adopt rules regarding what constitutes a clean claim for purposes of billing.

When implementing this subdivision, the Secretary shall balance the need for LMEs to exercise discretion in the discharge of their LME functions with the need of qualified providers for a uniform system of doing business with public entities.

(33) Develop and implement critical performance indicators to be used to hold LMEs accountable for managing the mental health, developmental disabilities, and substance abuse services system. The performance system indicators shall be implemented no later than July 1, 2007."

SECTION 5. Article 4 of Chapter 122C is amended by adding a new Part to read:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

(a) Area authorities and county programs shall establish committees made up of consumers and family members to be known as Consumer and Family Advisory Committees (CFACS). A local CFAC shall be a self-governing and a self-directed organization that advises the area authority or county program in its catchment area on the planning and management of the local public mental health, developmental disabilities, and substance abuse services system.

Each CFAC shall adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters. At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than two consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

(c) The CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the local business plan.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.

(4) Review and comment on the area authority or county program budget.

(5) Participate in all quality improvement measures and performance indicators.

(6) Submit to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.

(d) The director of the area authority or county program shall provide sufficient staff to assist the CFAC in implementing its duties under subsection (c) of this section.

The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on business plans and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

"**§ 122C-171. State Consumer and Family Advisory Committee.**

(a) There is established the State Consumer and Family Advisory Committee (State CFAC). The State CFAC shall be shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

(b) The State CFAC shall be composed of 21 members. The members shall be composed exclusively of adult consumers of mental health, developmental disabilities, and substance abuse services; and family members of consumers of mental health, developmental disabilities, and substance abuse services. The terms of members shall be three years, and no member may serve more than two consecutive terms. Vacancies shall be filled by the appointing authority. The members shall be appointed as follows:

(1) Nine by the Secretary. The Secretary's appointments shall reflect each of the disability groups. The terms shall be staggered so that terms of three of the appointees expire each year.

(2) Three by the General Assembly upon the recommendations of the President Pro Tempore of the Senate, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(3) Three by the General Assembly upon the recommendations of the Speaker of the House of Representatives, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(4) Three by the Council of Community Programs, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(5) Three by the North Carolina Association of County Commissioners, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(c) The State CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) Identify service gaps and underserved populations.
(3) Make recommendations regarding the service array and monitor the development of additional services.
(4) Review and comment on the State budget for mental health, developmental disabilities, and substance abuse services.
(5) Participate in all quality improvement measures and performance indicators.
(6) Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
(7) Provide technical assistance to local CFACs in implementing their duties.

(d) The Secretary shall provide sufficient staff to assist the State CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on the State Plan and departmental budget, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

(e) State CFAC members shall receive the per diem and allowances prescribed by G.S. 138-5 for State boards and commissions."

SECTION 6.(a) Notwithstanding G.S. 143-23, an area authority or a county program may transfer from one age or disability category to a different age or disability category up to fifteen percent (15%) of the funds initially allocated to the age or disability category from which funds are being transferred. Prior to the transfer, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall verify that the transfer meets applicable federal requirements. Area authorities and county programs shall:

(1) Publicly document that they have addressed the service needs of the category from which the funds are being transferred before any transfer may occur; and
(2) Submit the required documentation to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Fiscal Research Division within 15 days of making the transfer.

SECTION 6.(b) This section expires July 1, 2007.

SECTION 7. G.S. 122C-3(14) reads as rewritten:

"**§ 122C-3. Definitions.**

As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. ~~When the services offered are provided to individuals who are mentally ill or developmentally disabled, these~~ These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. ~~When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more.~~ Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "State facility", which is a facility that is operated by the Secretary;

g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers."

SECTION 8. Except as otherwise provided, this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 2077 DATE 6/27/06

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

Rep.)
) Nesbitt
Sen.)

moves to amend the bill on page 7, lines 23 - 24

( ) WHICH CHANGES THE TITLE

by rewriting the lines to read:

"area authority board to fill concurrently no more than ~~one category~~ two categories of membership if the member has the qualifications or attributes of ~~more than one category~~ the two categories of membership."

SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 2077*

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

H2077-ASQ-31 [v.1]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Senator Purcell

moves to amend the bill on page 17, line 40, by rewriting the line to read:

"**SECTION 8.** Except as otherwise provided, this act is effective when it becomes law.".

SIGNED William R Purcell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 2077*

Committee Substitute Favorable 6/5/06

PROPOSED SENATE COMMITTEE SUBSTITUTE H2077-CSLN-79 [v.7]

6/26/2006 5:32:20 PM

Short Title: Mental Health Reform Changes. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES WITH RESPECT TO THE IMPLEMENTATION OF MENTAL HEALTH REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-142(a) reads as rewritten:

"**§ 122C-142. Contract for services.**

(a) When the area authority contracts with persons for the provision of services, ~~the area authority~~ it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. However, an area authority or county program may amend the contract to comply with any court-imposed duty or responsibility. Terms of the standard contract shall require the area authority to monitor the contract to assure that rules and State statutes are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided, and the client outcomes. The Secretary may also monitor contracted services to assure that rules and State statutes are met."

SECTION 2.(a) G.S. 122C-102 reads as rewritten:

"**§ 122C-102. State Plan for Mental Health, Developmental Disabilities, and Substance Abuse ~~Services.~~Services; system performance measures.**

(a) Purpose of State Plan. – The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and county programs over a three-year period of time and benchmarks for determining whether progress is being made towards

those goals. It shall also identify data that will be used to measure progress towards the specified goals. In order to increase the ability of the State, area authorities, county programs, private providers, and consumers to successfully implement the goals of the State Plan, the Department shall not adopt or implement policies that are inconsistent with the State Plan without first consulting with the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Content of State Plan. – The State Plan shall include the following:

(1) Vision and mission of the State Mental Health, Developmental Disabilities, and Substance Abuse Services system.

~~(2) Organizational structure of the Department and the divisions of the Department responsible for managing and monitoring mental health, developmental disabilities, and substance abuse services.~~

(3) Protection of client rights and consumer involvement in planning and management of system services.

(4) Provision of services to targeted populations, including criteria for identifying targeted populations.

(5) Compliance with federal mandates in establishing service priorities in mental health, developmental disabilities, and substance abuse.

(6) Description of the core services that are available to all individuals in order to improve consumer access to mental health, developmental disabilities, and substance abuse services at the local level.

(7) Service standards for the mental health, developmental disabilities, and substance abuse services system.

(8) Implementation of the uniform portal process.

(9) Strategies and schedules for implementing the service plan, including consultation on Medicaid policy with area and county programs, qualified providers, and others as designated by the Secretary, intersystem collaboration, promotion of best practices, technical assistance, outcome-based monitoring, and evaluation.

(10) A plan for coordination of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services with the Medicaid State Plan, and NC Health Choice.

(11) A business plan to demonstrate efficient and effective resource management of the mental health, developmental disabilities, and substance abuse services system, including strategies for accountability for non-Medicaid and Medicaid services.

(12) Strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of State funding across county programs and area authorities by January 1, 2007, including methods to identify service gaps and to ensure equitable use of State funds to fill those gaps among all counties.

(c) State Performance Measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer-focused outcomes, individualized planning and

supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, on the State's progress in these performance areas."

SECTION 2.(b) The North Carolina Department of Health and Human Services (DHHS) shall review all State Plans for Mental Health, Developmental Disabilities, and Substance Abuse Services, implemented after July 1, 2001, and before the effective date of this act and produce a single document that contains a cumulative statement of all still applicable provisions of those Plans. This cumulative document shall constitute the State Plan until July 1, 2007.

DHHS and the Secretary shall also identify those provisions in G.S. 122C-112.1, prior State Plans, and directives or communications by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services that must be adopted as administrative rules in order to be enforceable and undertake to adopt those rules.

SECTION 3.(a) G.S. 122C-117(c) reads as rewritten:

"(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. ~~to each member of the board of county commissioners the quarterly report of the area authority.~~ The county finance officer shall provide the quarterly report to the board of county commissioners at next regularly scheduled meeting of the board. The clerk to the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners."

SECTION 3.(b) Article 23 of Chapter 153A of the General Statutes is amended by adding the following new section to read:

"**§ 153A-453. Quarterly reports of Mental Health, Developmental Disabilities, and Substance Abuse Services area authority or county program.**

Quarterly reports by the area director and finance officer of Mental Health, Developmental Disabilities, and Substance Abuse Services area authorities or county programs shall be submitted to the county finance officer as provided under G.S. 122C-117(c)."

SECTION 4.(a) G.S. 122C-3 is amended by adding the following new subdivision to read:

"**§ 122C-3. Definitions.**

~~As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:~~The following definitions apply in this Chapter:

...

(20b) "Local management entity" or "LME" means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.

..."

SECTION 4.(b) G.S. 122C-111 reads as rewritten:

"**§ 122C-111. Administration.**

The Secretary shall administer and enforce the provisions of this Chapter and the rules of the Commission and shall operate State facilities. An area director or program director shall (i) manage the public mental health, developmental disabilities, and substance abuse system for ~~administer the programs of~~ the area authority or county ~~program, as applicable,~~ program according to the local business plan, and (ii) enforce applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area and county program directors and State facility directors shall provide for the coordination of public services between area authorities, county programs, and State facilities. The area authority or county program shall monitor the provision of mental health, developmental disability, and substance abuse services for compliance with the law, which monitoring and management shall not supersede or duplicate the regulatory authority or functions of agencies of the Department."

SECTION 4.(c) G.S. 122C-115.2(a) reads as rewritten:

"**§ 122C-115.2.** ~~Business~~ LME business plan required; content, process, certification.

(a) Every county, through an area authority or county program, shall provide for the development, review, and approval of ~~a~~ an LME business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services. ~~A~~ An LME business plan shall provide detailed information ~~on~~ regarding how the area authority or county program will meet State standards, laws, and rules for ensuring quality mental health, developmental disabilities, and substance abuse services, including outcome measures for evaluating program effectiveness. The business plan shall be in effect for at least three State fiscal years."

SECTION 4.(d) Article 4 of Chapter 122C is amended by adding a new section to read:

"**§ 122C-115.4. Functions of local management entities.**

(a) Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME include all of the following:

(1) Access for all citizens to the core services described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider endorsement, monitoring, technical assistance, capacity development and quality control. An LME may remove a provider's endorsement if a provider fails to meet defined quality criteria or fails to provide required data to the LME.

(3) Utilization management, utilization review and determination of the appropriate level and intensity of services including the review and approval of the person centered plans for consumers who receive State-funded services. Concurrent review of person centered plans for all consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospital and other State facility utilization. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function includes the direct monitoring of the effectiveness of person centered plans. It also includes the initiation of and participation in the development of required modifications to the plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers and review of consumer charts.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds, and information management for the delivery of publicly funded services.

(c) Subject to all applicable State and federal laws and rules established by the Secretary, an area authority, or county program or consolidated human services agency may contract with a public or private entity for the implementation of LME functions articulated under subsection (b) of this section.

(d) Except as provided in G.S. 122C-142.1 and G.S. 122C-125, the Secretary may not remove from an LME any function enumerated under subsection (b) of this section unless all of the following applies:

(1) The LME fails during the previous three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).

(2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at

least six months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.

(3) If, after six months of receiving technical assistance from the Secretary the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement on behalf of the LME from which the function has been removed.

(e) Notwithstanding subdivision (d) of this section, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may temporarily remove an LME function after consultation with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(f) The Commission shall adopt rules regarding the following matters:

(1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.

(2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers with a disability group.

(3) The notice and procedural requirements for removing one or more LME functions under subsection (d) of this section."

SECTION 4.(e) G.S. 122C-118.1(a) reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties and service a catchment area with a population of more than 500,000 may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, ~~equitable~~ representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include ~~an individual~~ two individuals with financial ~~expertise or a county finance officer,~~ expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or

without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~At least~~ Not more than fifty percent (50%) of the members of the area board shall represent the following:

(1) A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.

(2) A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.

(3) ~~A~~ At least one family member or ~~an~~ individual from a citizens' ~~organizations~~ organization composed primarily of consumers or their family members, representing the interests of individuals:

a. With mental illness; ~~and~~

b. In recovery from addiction; ~~and~~ or

c. With developmental disabilities.

(4) ~~Openly~~ At least one openly declared ~~consumers:~~consumer:

a. With mental illness; ~~and~~

b. With developmental ~~disabilities; and~~ disabilities; or

c. In recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity. The terms of county commissioners on an area board are concurrent with their terms as county commissioners. The terms of the other members on the area board shall be for ~~four~~ three years, except that upon the initial formation of an area board ~~one-fourth~~ one-third shall be appointed for one year, ~~one-fourth~~ one-third for two years, ~~one-fourth for three years,~~ and all remaining members for ~~four~~ three years. Members ~~other than county commissioners~~ shall not be appointed for more than two consecutive terms. Board members serving as of July 1, 2006, may remain on the board for one additional term.

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 4.(f) G.S. 122C-115.1(g) reads as rewritten:

"(g) In a single-county program, an advisory committee shall be appointed by the board of county commissioners and shall report to the county manager. The appointments shall take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. ~~At least fifty percent (50%) of the~~ The membership shall conform to the requirements in ~~G.S. 122C-118.1(b)(1)-(4).~~ G.S. 122C-118.1. In a multicounty program,

the advisory committee shall be appointed in accordance with the terms of the interlocal agreement."

SECTION 4.(g) G.S. 122C-115.1(a) reads as rewritten:

"**§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.**

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. Except when specifically waived by the Secretary, the program director shall meet the following minimum qualifications:

a. Masters degree,

b. Related experience, and

c. Management experience.

(3) A targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program.

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. ~~At least fifty percent (50%) of the~~The membership shall conform to the requirements provided in ~~G.S. 122C-118.1(b)(1)-(4).~~G.S. 122C-118.1."

SECTION 4.(h). Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-120.1 Job classifications; director & finance officer.**

(a) The Office of State Personnel shall develop a job classification for director of an area authority or county program that reflects the skills required of an individual operating a local management entity. The Office of State Personnel shall also review the job classifications for area authority and county program finance officers to determine whether they reflect the skills necessary to manage the finances of a local management entity. The Commission shall adopt a job classification for director and any new or revised job classifications for finance officers no later than December 31, 2006.

(b) The job classifications developed under subsection (a) of this section shall apply to persons newly hired on or after January 1, 2007."

SECTION 4.(i) Effective January 1, 2007, G.S. 122C-115.1(a), as amended by Section 4(g) of this act reads as rewritten:

"**§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.**

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. Except when specifically waived by the Secretary, the program director shall meet all the following minimum qualifications:

a. Masters ~~degree,~~degree.

b. Related ~~experience, and~~ experience.

c. Management experience.

d. Any other qualifications required under G.S. 122C-120.1.

(3) A targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program.

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the requirements provided in G.S. 122C-118.1."

SECTION 4.(j) Effective January 1, 2007, G.S. 122C-115.1(f) reads as rewritten:

"(f) In a single-county program, the program director shall be appointed by the county manager. In a multicounty program, the program director shall be appointed in accordance with the terms of the interlocal agreement.

Except when specifically waived by the Secretary, the program director in a single county program shall meet all the following minimum qualifications:

(1) Masters degree.

(2) Related experience.

(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1."

SECTION 4.(k) Effective January 1, 2007, G.S. 122C-121(d) reads as rewritten:

"(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:
(1) Masters ~~degree;~~degree.
(2) Related ~~experience; and~~ experience.
(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1."

SECTION 4.(l) G.S. 122C-141 is amended by adding two new subsections to read:

(d) If two or more counties enter into an interlocal agreement under Article 20 of Chapter 160A of the General Statutes to be a public provider of mental health, developmental disabilities or substance abuse services ("public provider"), before an LME may enter into a contract with the public provider, all of the following must apply:
(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Secretary. A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.
(2) The LME must adopt a conflict of interest policy that applies to all provider contracts.
(3) The interlocal agreement must provide that any liabilities of the public provider shall be paid from its unobligated surplus funds and that if those funds are not sufficient to satisfy the indebtedness, the remaining indebtedness shall be apportioned to the participating counties."

(d1) The Secretary shall ensure that there is fair competition among providers. The Department shall study the effect of subsection (d) of this section and shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by December 1, 2009."

SECTION 4.(m) G.S. 122C-112.1(a) reads as rewritten:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:
(1) Oversee development and implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.
(2) Enforce the provisions of this Chapter and the rules of the Commission and the Secretary.
(3) Establish a process and criteria for the submission, review, and approval or disapproval of LME business plans submitted by area authorities and ~~counties~~ county programs for the management ~~and provision~~ of mental health, developmental disabilities, and substance abuse services.

(4) Adopt rules specifying the content and format of LME business plans.

(5) Review LME business plans and, upon approval of the ~~business~~ plan, certify the submitting area authority or county program to ~~provide~~ manage the delivery of mental health, developmental disabilities, and substance abuse ~~services.~~services in the applicable catchment area.

(6) Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities, county programs, and all providers of public services with State and federal policy, law, and standards. ~~Procedures~~ The procedures shall include the development and use of critical performance measures and report cards for each area authority and county program.

(7) Conduct regularly scheduled monitoring and oversight of area authority, county programs, and all providers of public services. Monitoring and oversight shall ~~include~~ be used to assess compliance with the ~~program~~ LME business ~~plan,~~ plan and implementation of core ~~administrative functions, and fiscal and administrative practices and~~ LME functions. Monitoring shall also ~~address~~ include the examination of LME and provider performance on outcome ~~measures,~~ measures including adherence to best practices, the assessment of consumer satisfaction, and the review of client rights ~~complaints, and adherence to best practices.~~complaints.

(8) Make findings and recommendations based on information and data collected pursuant to subdivision (7) of this subsection and submit these findings and recommendations to the applicable area authority board, county program director, board of county commissioners, providers of public services, and to the Local Consumer Advocacy Office.

(9) ~~Assist~~ Provide ongoing and focused technical assistance to area authorities and county programs in the implementation of the LME functions and the establishment and operation of community-based programs. The technical assistance required under this subdivision includes, but is not limited to the technical assistance required under G.S. 122C-115.4(d)(2). The Secretary shall include in the State Plan a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities and county programs in achieving these functions.

(10) Operate State facilities and adopt rules pertaining to their operation.

(11) Develop a unified system of services provided ~~in area, county, and~~ at the community level, by State facilities, and by providers enrolled or under a contract with the ~~State.~~State and an area authority or county program.

(12) Adopt rules governing the expenditure of all funds for mental health, developmental disabilities, and substance abuse programs and services.

(13) Adopt rules to implement the appeal procedure authorized by G.S. 122C-151.2.
(14) Adopt rules for the implementation of the uniform portal process.
(15) Except as provided in G.S. 122C-26(4), adopt rules establishing procedures for waiver of rules adopted by the Secretary under this Chapter.
(16) Notify the clerks of superior court of changes in the designation of State facility regions and of facilities designated under G.S. 122C-252.
(17) Promote public awareness and understanding of mental health, mental illness, developmental disabilities, and substance abuse.
(18) Administer and enforce rules that are conditions of participation for federal or State financial aid.
(19) Carry out G.S. 122C-361.
(20) Monitor the fiscal and administrative practices of area authorities and county programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance abuse services. The Secretary shall ensure maximum accountability by area authorities and county programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles.
(21) Provide technical assistance, including conflict resolution, to counties in the development and implementation of area authority and county program business plans and other matters, as requested by the county.
(22) Develop a methodology to be used for calculating county resources to reflect cash and in-kind contributions of the county.
(23) Adopt rules establishing program evaluation and management of mental health, developmental disabilities, and substance abuse services.
(24) Adopt rules regarding the requirements of the federal government for grants-in-aid for mental health, developmental disabilities, or substance abuse programs which may be made available to area authorities or county programs or the State. This section shall be liberally construed in order that the State and its citizens may benefit from the grants-in-aid.
(25) Adopt rules for determining minimally adequate services for purposes of G.S. 122C-124.1 and G.S. 122C-125.
(26) Establish a process for approving area authorities and county programs to provide services directly in accordance with G.S. 122C-141.
(27) Sponsor training opportunities in the fields of mental health, developmental disabilities, and substance abuse.

(28) Enforce the protection of the rights of clients served by State facilities, area authorities, county programs, and providers of public services.

(29) Adopt rules for the enforcement of the protection of the rights of clients being served by State facilities, area authorities, county programs, and providers of public services.

(30) Prior to requesting approval to close a State facility under G.S. 122C-181(b):

a. Notify the Joint Legislative Commission on Governmental Operations, the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and members of the General Assembly who represent catchment areas affected by the closure; and

b. Present a plan for the closure to the members of the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services for their review, advice, and recommendations. The plan shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the committees to which the plan is presented under this subdivision.

(31) Ensure that the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services is coordinated with the Medicaid State Plan and NC Health Choice.

(32) Implement standard forms, quality measures, contracts, processes, and procedures to be used by all area authorities and county programs with other public and private service providers. The Secretary shall consult with LMEs, CFACs, counties, and qualified providers regarding the development of any forms, processes, and procedures required under this subdivision. Any document, process procedure developed under this subdivision shall place an obligation upon providers to transmit to LMEs timely client information and outcome data. The Secretary shall also adopt rules regarding what constitutes a clean claim for purposes of billing.

When implementing this subdivision, the Secretary shall balance the need for LMEs to exercise discretion in the discharge of their LME functions with the need of qualified providers for a uniform system of doing business with public entities.

(33) Develop and implement critical performance indicators to be used to hold LMEs accountable for managing the mental health, developmental disabilities, and substance abuse services system. The performance system indicators shall be implemented no later than July 1, 2007."

SECTION 5. Article 4 of Chapter 122C is amended by adding a new Part to read:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

(a) Area authorities and county programs shall establish committees made up of consumers and family members to be known as Consumer and Family Advisory Committees (CFACS). A local CFAC shall be a self-governing and a self-directed organization that advises the area authority or county program in its catchment area on the planning and management of the local public mental health, developmental disabilities, and substance abuse services system.

Each CFAC shall adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters. At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than two consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services;

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services; and

(c) The CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the local business plan.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.

(4) Review and comment on the area authority or county program budget.

(5) Participate in all quality improvement measures and performance indicators.

(6) Submit to the State Consumer and Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.

(d) The director of the area authority or county program shall provide sufficient staff to assist the CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved

populations, training to review and comment on business plans and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

"**§ 122C-171. State Consumer and Family Advisory Committee.**

(a) There is established the State Consumer and Advisory Committee (State CAFC). The State CFAC shall be shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

(b) The State CFAC shall be composed of 21 members. The members shall be composed exclusively of adult consumers of mental health, developmental disabilities, and substance abuse services; and family members of consumers of mental health, developmental disabilities, and substance abuse services. The terms of members shall be three years, and no member may serve more than two consecutive terms. Vacancies shall be filled by the appointing authority. The members shall be appointed as follows:

(1) Nine by the Secretary. The Secretary's appointments shall reflect each of the disability groups. The terms shall be staggered so that terms of three of the appointees expire each year.

(2) Three by the General Assembly upon the recommendations of the President Pro Tempore of the Senate, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(3) Three by the General Assembly upon the recommendations of the Speaker of the House of Representatives, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(4) Three by the Council of Community Programs, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(5) Three by the North Carolina Association of County Commissioners, one each of whom shall come from the three State regions for institutional services (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(c) The State CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.
(4) Review and comment on the State budget for mental health, developmental disabilities, and substance abuse services.
(5) Participate in all quality improvement measures and performance indicators.
(6) Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
(7) Provide technical assistance to local CFACs in implementing their duties.

(d) The Secretary shall provide sufficient staff to assist the State CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on the State Plan and departmental budget, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

(e) State CFAC members shall receive the per diem and allowances prescribed by G.S. 138-5 for State boards and commissions."

SECTION 6. (a) Notwithstanding G.S. 143-23, an area authority or a county program may transfer from one age or disability category to a different age or disability category up to fifteen percent (15%) of the funds initially allocated to the age or disability category from which funds are being transferred. Prior to the transfer, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall verify that the transfer meets applicable federal requirements. Area authorities and county programs shall:

(1) Publicly document that they have addressed the service needs of the category from which the funds are being transferred before any transfer may occur, and
(2) Submit the required documentation to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Fiscal Research Division within 15 days of making the transfer.

SECTION 6.(b) This section expires July 1, 2007.

SECTION 7. G.S. 122C-3(14) reads as rewritten:

"**§ 122C-3. Definitions.**

As used in this Chapter, unless another meaning is specified or the context clearly requires otherwise, the following terms have the meanings specified:

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:
a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program. For

the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. ~~When the services offered are provided to individuals who are mentally ill or developmentally disabled, these~~ These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. ~~When the services offered are provided to individuals who are substance abusers, these services shall include all outpatient services, day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more.~~ Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "State facility", which is a facility that is operated by the Secretary;

g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers."

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

HOUSE BILL 2077:
Strengthen MH/DD/SA Private Providers

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 26, 2006
Introduced by:	Reps. Insko, Alexander, Barnhart, Earle	**Summary by:**	Shawn Parker
Version:	PCS to Second Edition H2077-CSLN-79		Legislative Analyst

SUMMARY: The Senate Proposed Committee Substitute combines the policy provisions of HB2077 (Strengthen MH-DD-SA Providers), HB2080 (Strengthen LMEs), HB2081 (Strengthen State MH/DD/SAS Reform), HB 2082 (Increase MH-DD-SA Crisis Services), HB 2083(Consumer and Family Advisory Committees) into a single bill. These provisions came as recommendations of the Joint Legislative Oversight Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC). These are the first major revisions to the laws implementing mental health reform since 2001.

This act is effective when it becomes law.

BILL ANALYSIS: The following is a Section by Section analysis of the bill. Sections that are not included in the analysis make only technical or conforming changes to the statutes.

Section 1 requires area authorities when contracting with persons for provisions of services, to use the standard contract adopted by the Secretary. The bill allows area authorities to amend the contract to comply with a court-imposed duty.

Section 2(a) directs the Department of Health and Human Services (Department) to revise the State Plan to make it more of a strategic planning document and to also include a mechanism to measure the State's progress towards increased performance in the delivery of MH/DD/SA services.

Section 2(b) directs the Department to produce a cumulative document addressing applicable provisions of State plans implemented since July 1, 2001. The document will constitute the State Plan until July 1, 2007.

Sections 3(a-b) clarify the existing process by which an LME must submit its quarterly financial statement to the board of county commissioners of the counties that are members of the LME.

Section 4(a) creates a statutory definition for "Local Management Entity" (LME). This is a term that has been used for the past 5 years to describe the 6 different types of local public agency that is responsible for the management of publicly funded mental health, developmental disabilities, and substance abuse services (SA/DD/SAS).

Section 4(b) clarifies that it is the duty of the director of an LME to both manage the public MH/DD/SAS system and to enforce all applicable laws.

Section 4(c) is a technical correction to rename business plans as LME business plans.

Section 4(d) creates a new law (G.S. 122C-115.4) that clearly outlines the functions of an LME to be the management and oversight of the public MH/DD/SAS system at the local level. The specific functions are consistent with current practice, but have not been clearly articulated in the law. The functions are: access to service, provider endorsement and monitoring, review and approval of services for non-Medicaid eligible consumers, concurrent review of person-centered plans, authorization of State facility bed days, care coordination, community collaboration, and financial management. LMEs would

be allowed to subcontract any of these functions consistent with applicable laws. The Secretary could remove one or more of an LME's functions if the LME is not performing the function adequately as measured by critical performance measures adopted by the Secretary.

Sections 4(e-g) relate to the composition of an LME board. It requires at least 2 of the members have financial expertise and not more than fifty percent (50%) of the members can be consumers, family members, or advocates. It also limits board terms to 3 years and two consecutive terms. A member of an LME board as of July 1, 2006 could serve one more 3 year term.

Sections 4(h-k) relate to the qualifications of the director of an LME. It would add requirements of the job classification for an LME director as adopted by the State Personnel Commission. The requirements would apply to persons hired on or after January 1, 2007.

Section 4(l) clarifies that counties may be providers of services to MH/DD/SA consumers provided the county meets the provider qualifications established by the Secretary. The Commission on MH/DD/SAS shall adopt rules to ensure fair competition. The Department shall review the effect of this provision and report to the LOC by December 1, 2009 and the LOC shall make recommendations to the 2009 General Assembly whether to modify or extend the authority

Section 4(m) amends the powers and duties of the Secretary regarding the provision of local MH/DD/SA services. The changes clarify the purpose of the regular monitoring by the Secretary of LMEs and providers, to provide ongoing technical assistance to LMEs to implement their management functions, to adopt uniform contracts and processes, and to develop and implement critical performance indicators to be used to hold LMEs accountable for their management functions.

Section 5 amends Article 4 of Chapter 122C by adding a new Part which requires area authorities and county programs to establish committees made up of consumers and family members. The CFACS will be self-governing and self directed organizations that advise the LME in its catchment area on the management of the local public mental health, developmental disabilities and substance abuse services system. Each disability group will be equally represented and will reflect as closely as possible the racial and ethnic composition of the catchment area.

The local CFAC is responsible for

- Reviewing and monitoring the local business plan
- Identifying service gaps and underserved populations
- Making recommendations regarding service array
- Reviewing the area authority or county program's budget
- Participating in quality improvement measures
- Submitting its findings to the State Consumer and Family Advisor Committee

The section also establishes the State Consumer and Family Advisory Committee as a self governing and self directed organization that advise the Department of Health and Human Services and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system. The State CFAC will be composed of 21 members who are parents of consumers or adult consumers of mental health, developmental disabilities, and substance abuse services. The Secretary, the General Assembly, the Council of Community Programs, and the North Carolina Association of County Commissioners will have specific appointing authority.

The State CFAC is responsible for:

- Reviewing and monitoring the State Plan for MH-DD-SAS
- Identifying service gaps and underserved populations
- Making recommendations regarding service array
- Reviewing the State budget for MH-DD-SAS
- Participating in quality improvement measures
- Receiving findings from the local Consumer and Family Advisor Committee
- Provide Technical Assistance to local CFACS in implementing their duties

State CFAC members will receive per diem and allowances prescribed by G.S. 138-5.

Section 6(a) authorizes an LME, notwithstanding G.S. 143-23, to transfer up to 15% of funds allocated from one age or disability category to another if the transfer meets applicable federal requirements, and the LME publicly document that they have addressed the service needs of the category from which funds are being transferred and submit the required documentation to the Division of MH-DD-SAS and the Fiscal Research Division within 15 days of the transfer.

Section 6(b) provides a sunset of July 1, 2007 to the provision in Section 6(a) of the act.

Section 7 adjusts the definition of licensable facility in G.S. 122C-3(14) to make facility licensure requirements for outpatient substance abuse services consistent with the facility licensure requirements for outpatient mental health or developmental disability services.

Section 8 makes the act effective when it becomes law.

EFFECTIVE DATE: This act is effective when it becomes law.

Kory Goldsmith, counsel to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Service, substantially contributed to this summary.

H2077e2-SMSQ-CSLN-79

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 27, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Bone	Bone & Asso.
Lee Hodges	ICCU
Shannon Jones	Professional Administrative Inc.
Peggy Myers	Self
Bob Edmiston	NCPL
Lanier Carsten	Carsten Fuqua
STEVE KEENE	NC Med Soc.
Sharon Pearce	Carolina Anesthesia
Mark Fleming	Union Atty
Chip Baggett	Buncombe County Medical Society
DAVID BRAND	P+S

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 27, 2006**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby C. Swanzebon	NMSS
Janet Schanzenbach	NC Council
Jud Nadal	Eastern Seals UCP
Gail Quest	NC Nurses Association
Linda Brown	NC Nurses Assoc.
Amilda. Horne MD	private practice psychiatrist + NCPA
Robin Huffman	NC Psychiatric Assoc. / Coalition 2001
Colleen Kochanek	NCCEP
Dave Richard	The Arc
Trent Praytor	NCNA
Joanne Stevens	NCNA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 27, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Purcell	
Tom Vitazkova	Action for Children
Fawn Pattison	Ag Resources Ctr.
John Tate	MHA/NC - C2001
Sally Cameron	NC Psychological Assoc C2001
Michael Neka	Conservation Council
Kaylene Lewek	NC Voices

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 27, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roz Sawyer	NCACC
Lu Ann Coe Perryman	NCPA

Senate Health Care Committee
Wednesday, June 28, 2006, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1502	**Schoolchildren's Health Act.**	**Representative Martin** **Representative McLawhorn** **Representative Lucas**
HB 2059	**LTC Fines Posted on Internet.**	**Representative Bordsen** **Representative Earle** **Representative Weiss**
HB 1301	**Physical Therapy Bd./Competency of Licensees.**	**Representative Allen**
HB 2200	**Enhance Embargo Auth/Protect Food Supply.**	**Representative Glazier** **Representative Cunningham**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 28, 2006

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

FAVORABLE

H.B.(CS #1) **2200** Enhance Embargo Auth/Protect Food Supply.

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) **1502** Schoolchildren's Health Act.

Draft Number:	PCS80669
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, June 29, 2006

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) **1301** Physical Therapy Bd./Competency of Licensees.

Draft Number:	PCS 50752
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Wednesday June 28, 2006
11:00 A.M.
Room 544, Legislative Office Building

Minutes

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 28, 2006, in Room 544 of the Legislative Office Building, with eight members present. Senator Stan Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell moved to hear the PCS for HB 1502, ***Schoolchildren's Health Act,*** which passed. After a nice vigorous debate and three amendments from last week's meeting, Senator Dorsett moved for a favorable report as to the Committee Substitute, but unfavorable as to bill, which passed.

Senator Bingham told the committee that HB 2059, ***LTC Fines Posted on Internet***, is removed from today's calendar.

Representative Glazier was recognized to present HB 2200, ***Enhance Embargo Auth/protect Food Supply.*** The Joint Study Committee on Emergency Preparedness and Disaster Management Recovery recommended this bill. The bill authorizes the Secretary of Environment and Natural Resources or a local health director to exercise embargo authority concerning food or drink in an establishment subject to regulation of DENR (restaurants and hotels) or subject to an investigation by the local health director in the case of communicable diseases. The bill would also require the Department of Agriculture and Consumer Services, DENR and DHHS to jointly develop a plan to protect the food supply from intentional contamination. Senator Nesbitt moved for a favorable report, which passed unanimously.

Senator Purcell moved to consider the PCS for HB 1301, ***Physical Therapy Bd./Competency of Licensees***. Senator Purcell proposed an amendment to change the long title to add "and designating information released to patient safety organizations as confidential" and Section 3. Senator Dorsett moved to approve the amendment, which was adopted. Tom Mansfield, Director of Legal Department, NC Medical Board stated this improves the patient safety in North Carolina. Senator Nesbitt submitted another amendment with a title change to add, "to strengthen the authority of the North Carolina Medical Board to discipline physicians and certain others". Steve Kleen, NC Medical Society, stated he does support the amendment. The amendment was adopted. Senator Purcell submitted another amendment, which changed section 4. The amendment was adopted. Senator Purcell proposed another amendment, which adds to the long title, "to allow certain groups to practice as professional corporations". The amendment was adopted. Several people spoke including William Porter, NC Physical Therapy Association, Paul Pulley, Academy of Trial Lawyers, and Hugh Tillison, Executive

Director, NC Hospital Association. Senator Nesbitt made a motion to roll the amendments into a new PCS, favorable to the PCS, unfavorable to the original Bill. The motion passed.

The meeting adjourned at 11: 59 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1502

Committee Substitute Favorable 5/23/05

Short Title: Schoolchildren's Health Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO ENACT THE SCHOOLCHILDREN'S HEALTH ACT OF 2005.

Whereas, when school is in session, children spend 30% to 50% of their time at school; and

Whereas, it is incumbent upon State government to address public health and environmental issues in the classroom and on school grounds in order to protect the health of school-age children; and

Whereas, inexpensive and easy measures can be taken to provide a healthier learning environment for our children, and, in some instances, these measures actually offer a school district cost savings; and

Whereas, on March 4, 2004, a stakeholders group consisting of the Department of Public Instruction, the Department of Agriculture and Consumer Services, the North Carolina Cooperative Extension Service, the Agricultural Resources Center, the North Carolina Parent Teacher's Association, the N.C. Pest Control Association, The North Carolina State School Boards Association, Inc., and other entities signed a memorandum of understanding establishing their support for Integrated Pest Management (IPM) and creating a model school IPM policy; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act may be cited as the Schoolchildren's Health Act of 2005.

SECTION 2. The General Assembly makes the following findings:

(a) Arsenic-Treated Wood. –

(1) Effective 2004, arsenic-treated wood for residential uses has been removed from the marketplace under a voluntary agreement between the United States Environmental Protection Agency and the industry. Since this is a voluntary agreement, only a State ban will ensure that arsenic-treated wood is not used on school grounds in the future.

(2) Additionally, backstock arsenic-treated wood is still on the market in some places.

(3) A ban of CCA (chromated copper arsenate) treated wood for use in public schools is a reasonable safeguard measure.

(b) Mercury. –

(1) Mercury is a potent brain toxicant, and children, whose brains are still developing, are most vulnerable to its effects.

(2) Once introduced into the human body, mercury interferes with brain development and can lead to a number of developmental problems, including delayed language acquisition, impaired memory, and learning disabilities.

(c) Diesel Exhaust Fumes. –

(1) Because children's respiratory systems are still developing and they breathe more rapidly, children are more susceptible to air pollution than the average adult is.

(2) Diesel exhaust poses a particular risk to children, because it contains significant levels of small particles, known as fine particulate matter. This particulate matter is so fine that it can pass through the nose and throat and lodge in the lungs, possibly causing long-term adverse health effects.

(3) Particulate matter from diesel exhaust is associated with asthma and has been found to increase the risk of lung disease and heart disease. Additionally, it can bind to pollen in the air, further exacerbating allergies and asthma. Diesel exhaust is also known to contain several human carcinogens.

(4) School bus idling and bus queuing (nose-to-tail lineup of buses) dramatically increase the concentrations of detrimental particulate pollution inside school buses.

(d) Pesticides. –

(1) Because children's bodies are still developing, exposure to pesticides can have serious impacts on their long-term health.

(2) Schools may subject themselves to liability for immediate injuries to students, faculty, or other staff resulting from improper management of toxic chemicals such as pesticides.

(3) Schools can reduce or even eliminate the risks of pesticides by using simple, low-cost methods, such as Integrated Pest Management (IPM).

(4) With proper training, planning, and effective communication among affected parties, IPM can prevent pest problems, reduce the need for pesticide applications, and greatly improve the quality of the school environment.

(e) Mold and Mildew. –

(1) Mold and mildew problems occur in schools when moisture gets into the structure, thereby creating a friendly environment for excessive mold and mildew growth.

(2) Parents and school officials have become more aware of the health risks of mold, such as allergic reactions in children and adults, as the

public has become more aware of the problems associated with certain molds.

SECTION 3. G.S. 115C-12 is amended by adding a new subdivision to read:

"(33) Duty to Protect the Health of School-Age Children From Toxicants at School. – The State Board shall address public health and environmental issues in the classroom and on school grounds by doing all of the following:

a. Develop guidelines for sealing existing arsenic-treated wood in playground equipment or establish a time line for removing existing arsenic-treated wood on playgrounds and testing the soil on school grounds for contamination caused by the leaching of arsenic-treated wood in other areas where children may be at particularly high risk of exposure.

b. Establish guidelines to reduce students' exposure to diesel emissions that can occur as a result of unnecessary school bus idling, nose-to-tail parking, and inefficient route assignments.

c. Study methods for mold and mildew prevention and mitigation and incorporate recommendations into the public school facilities guidelines as needed.

d. Establish guidelines for Integrated Pest Management consistent with the policy of The North Carolina School Boards Association, Inc., as published in 2004. These guidelines may be updated as needed to reflect changes in technology.

e. Establish guidelines for notification of students' parents, guardians, or custodians as well as school staff of pesticide use on school grounds."

SECTION 4. G.S. 115C-47 is amended by adding four new subdivisions to read:

"(45) To Address the Use of Pesticides in Schools. – Local boards of education shall adopt policies that address the use of pesticides in schools. These policies shall:

a. Require the principal or the principal's designee to annually notify the students' parents, guardians, or custodians as well as school staff of the schedule of pesticide use on school property and their right to request notification. Such notification shall be made, to the extent possible, at least 72 hours in advance of nonscheduled pesticide use on school property. The notification requirements under this subdivision do not apply to the application of the following types of pesticide products: antimicrobial cleansers, disinfectants, self-contained baits and crack-and-crevice treatments, and any pesticide products classified by the United States Environmental Protection Agency as belonging to the U.S.E.P.A. Toxicity Class IV, "relatively nontoxic" (no signal word required on the product's

label). Nothing in this sub-subdivision shall be construed to create a private cause of action against any local board of education, its agents, or its employees.

b. Require the use of Integrated Pest Management. As used in this sub-subdivision, "Integrated Pest Management" or "IPM" means the comprehensive approach to pest management that combines biological, physical, chemical, and cultural tactics as well as effective, economic, environmentally sound, and socially acceptable methods to prevent and solve pest problems that emphasizes pest prevention and provides a decision-making process for determining if, when, and where pest suppression is needed and what control tactics and methods are appropriate.

(46) To Address Arsenic-Treated Wood in the Classroom and on School Grounds. – Local boards of education shall prohibit the purchase or acceptance of chromated copper arsenate-treated wood for future use on school grounds. Local boards of education shall seal existing arsenic-treated wood in playground equipment or establish a time line for removing existing arsenic-treated wood on playgrounds, according to the guidelines established under G.S. 115C-12(33). Local boards of education are encouraged to test the soil on school grounds for contamination caused by the leaching of arsenic-treated wood.

(47) To Address Mercury in the Classroom and on School Grounds. – Local boards of education are encouraged to remove and properly dispose of all bulk elemental mercury, chemical mercury, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers. Local boards of education shall prohibit the future use of bulk elemental mercury, chemical mercury compounds, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers.

(48) To Address Exposure to Diesel Exhaust Fumes. – Local boards of education shall adopt policies and procedures to reduce students' exposure to diesel emissions."

SECTION 5. G.S. 115C-47(45)b., as enacted by Section 4 of this act, becomes effective October 1, 2010. The remainder of this act becomes effective October 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1502

Committee Substitute Favorable 5/23/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H1502-CSRJ-38 [v.3]

6/27/2006 4:24:41 PM

Short Title: Schoolchildren's Health Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO ENACT THE SCHOOLCHILDREN'S HEALTH ACT OF 2006.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-12 is amended by adding a new subdivision to read:

"(33) Duty to Protect the Health of School-Age Children From Toxicants at School. – The State Board shall address public health and environmental issues in the classroom and on school grounds by doing all of the following:

a. Develop guidelines for sealing existing arsenic-treated wood in playground equipment or establish a time line for removing existing arsenic-treated wood on playgrounds and testing the soil on school grounds for contamination caused by the leaching of arsenic-treated wood in other areas where children may be at particularly high risk of exposure.

b. Establish guidelines to reduce students' exposure to diesel emissions that can occur as a result of unnecessary school bus idling, nose-to-tail parking, and inefficient route assignments.

c. Study methods for mold and mildew prevention and mitigation and incorporate recommendations into the public school facilities guidelines as needed.

d. Establish guidelines for Integrated Pest Management consistent with the policy of The North Carolina School Boards Association, Inc., as published in 2004. These guidelines may be updated as needed to reflect changes in technology.

e. Establish guidelines for notification of students' parents, guardians, or custodians as well as school staff of pesticide use on school grounds."

SECTION 2. G.S. 115C-47 is amended by adding four new subdivisions to read:

"(45) To Address the Use of Pesticides in Schools. – Local boards of education shall adopt policies that address the use of pesticides in schools. These policies shall:

a. Require the principal or the principal's designee to annually notify the students' parents, guardians, or custodians as well as school staff of the schedule of pesticide use on school property and their right to request notification. Such notification shall be made, to the extent possible, at least 72 hours in advance of nonscheduled pesticide use on school property. The notification requirements under this subdivision do not apply to the application of the following types of pesticide products: antimicrobial cleansers, disinfectants, self-contained baits and crack-and-crevice treatments, and any pesticide products classified by the United States Environmental Protection Agency as belonging to the U.S.E.P.A. Toxicity Class IV, "relatively nontoxic" (no signal word required on the product's label).

b. Require the use of Integrated Pest Management. As used in this sub-subdivision, "Integrated Pest Management" or "IPM" means the comprehensive approach to pest management that combines biological, physical, chemical, and cultural tactics as well as effective, economic, environmentally sound, and socially acceptable methods to prevent and solve pest problems that emphasizes pest prevention and provides a decision-making process for determining if, when, and where pest suppression is needed and what control tactics and methods are appropriate.

(46) To Address Arsenic-Treated Wood in the Classroom and on School Grounds. – Local boards of education shall prohibit the purchase or acceptance of chromated copper arsenate-treated wood for future use on school grounds. Local boards of education shall seal existing arsenic-treated wood in playground equipment or establish a time line for removing existing arsenic-treated wood on playgrounds, according to the guidelines established under G.S. 115C-12(33). Local boards of education are encouraged to test the soil on school grounds for contamination caused by the leaching of arsenic-treated wood.

(47) To Address Mercury in the Classroom and on School Grounds. – Local boards of education are encouraged to remove and properly dispose of all bulk elemental mercury, chemical mercury, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers. Local boards of education shall prohibit the future use of bulk elemental mercury, chemical mercury compounds,

and bulk mercury compounds used as teaching aids in science classrooms, not including barometers.

(48) To Address Exposure to Diesel Exhaust Fumes. – Local boards of education shall adopt policies and procedures to reduce students' exposure to diesel emissions."

SECTION 3. Nothing in this act shall be construed to create a private cause of action against the State Board of Education, a local board of education, or their agents or employees.

SECTION 4. G.S. 115C-47(45)b., as enacted by Section 2 of this act, becomes effective October 1, 2011. The remainder of this act becomes effective October 1, 2006.

HOUSE BILL 1502:
Schoolchildren's Health Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 27, 2006
Introduced by:	Reps. Martin, McLawhorn, Lucas	**Summary by:**	Sara Kamprath
Version:	PCS to Second Edition		Legislative Analyst

SUMMARY: ***The Proposed Committee Substitute for House Bill 1502 incorporates the 3 amendments that were adopted by the Senate Health Care Committee at the last meeting on June 21, 2006. The following are new amendments to the PCS: (1) a provision providing that nothing in the bill creates a private cause of action against the State Board of Education or the Board's agents or employees and (2) a technical change in the effective date clause of the bill.***

The PCS directs the State Board of Education to protect school-age children from toxicants by addressing certain public health and environmental issues in classrooms and on school grounds. The PCS also directs local boards of education to adopt policies and take steps to carry out the guidelines developed by the State Board of Education.

BILL ANALYSIS: **Section 1** of the PCS directs the State Board of Education to establish guidelines to address health and environmental issues related to:

- Sealing and removing arsenic-treated wood on playground equipment
- Reducing student exposure to diesel emissions
- Implementing Integrated Pest Management and procedures to notify parents, guardians and staff of pesticide use on school grounds

The State Board shall also study methods to prevent and mitigate mold and mildew and incorporate the recommendations into the public school facilities guidelines.

The PCS adds language directing the State Board to develop guidelines for testing the soil on school grounds for contamination from leaching of arsenic-treated wood in other areas where children may be at high risk for exposure.

Section 2 of the PCS adds four new duties for local school boards. The new duties address (i) giving parents and staff advance notification of pesticide application, (ii) banning future use of arsenic-treated wood in the classroom and school grounds, (iii) banning elemental mercury or chemical mercury compounds in the classroom and on school grounds, and (iv) reducing student exposure to diesel exhaust fumes.

Section 3 of the PCS also adds language that nothing in the bill shall create a private cause of action against any local board of education, its agents, or employees.

EFFECTIVE DATE: G.S. 115C-47(45)b. in Section 2 of the bill becomes effective October 1, 2011. The remainder of the bill becomes effective October 1, 2006.

BACKGROUND:

Arsenic-Treated Wood: Chromated copper arsenate (CCA) is a chemical wood preservative containing chromium, copper and arsenic that is used in pressure treated wood to prevent rotting. The US Environmental Protection Agency (EPA) reached an agreement with the manufacturers of wood preservative products to voluntarily phase out the use of CCA-treated wood. Starting in 2004, CCA-treated wood was no longer to be used in residential settings.

The EPA and the Consumer Product Safety Commission are currently conducting a two-year study of the effectiveness of sealants in preventing leaching of arsenic from CCA-treated wood. The study will end in August 2005 and a final report is expected at the end of the year.

Diesel Exhaust Fumes: In January 2001, the EPA adopted the Clean Diesel Trucks and Buses Rule that has more stringent standards for new diesel engines and fuels. Beginning in 2006, heavy-duty trucks and buses will be required to phase-in the use of lower sulfur fuels. These fuels will enable the effective use of modern-pollution control technology in new diesel engines. The new diesel engines will be phased-in beginning with the 2007 model year.

Pesticides: A model policy for Integrated Pest Management (IPM) was created in 2004 by the various stakeholders listed in the bill and is available to local school systems as a guide for developing their own policy.

Mold and Mildew: The Occupational and Environmental Epidemiology Branch (OEEB) of the Department of Health and Human Services has been providing local school systems with information, guidance and consultative services on indoor environmental quality since the 1980s. Recently, more and more schools have had to deal with mold contamination problems in their buildings. OEEB has personnel that can consult with school systems and conduct on-site evaluations.

CURRENT LAW:

§ 115C-524. Repair of school property; use of buildings for other than school purposes.

.....

(b) It shall be the duty of local boards of education and tax-levying authorities, in order to safeguard the investment made in public schools, to keep all school buildings in good repair to the end that all public school property shall be taken care of and be at all times in proper condition for use. It shall be the duty of all principals, teachers, and janitors to report to their respective boards of education immediately any unsanitary condition, damage to school property, or needed repair. All principals, teachers, and janitors shall be held responsible for the safekeeping of the buildings during the school session and all breakage and damage shall be repaired by those responsible for same, and where any principal or teacher shall permit damage to the public school buildings by lack of proper discipline of pupils, such principal or teacher shall be held responsible for such damage: Provided, principals and teachers shall not be held responsible for damage that they could not have prevented by reasonable supervision in the performance of their duties.

.....

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1502

Committee Substitute Favorable 5/23/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H1502-PCS80669-RJ-38

Short Title: Schoolchildren's Health Act. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO ENACT THE SCHOOLCHILDREN'S HEALTH ACT OF 2006.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-12 is amended by adding a new subdivision to read:

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b. Establish guidelines to reduce students' exposure to diesel emissions that can occur as a result of unnecessary school bus idling, nose-to-tail parking, and inefficient route assignments.

c. Study methods for mold and mildew prevention and mitigation and incorporate recommendations into the public school facilities guidelines as needed.

d. Establish guidelines for Integrated Pest Management consistent with the policy of The North Carolina School Boards Association, Inc., as published in 2004. These guidelines may be updated as needed to reflect changes in technology.

e. Establish guidelines for notification of students' parents, guardians, or custodians as well as school staff of pesticide use on school grounds."

SECTION 2. G.S. 115C-47 is amended by adding four new subdivisions to read:

"(45) To Address the Use of Pesticides in Schools. – Local boards of education shall adopt policies that address the use of pesticides in schools. These policies shall:

a. Require the principal or the principal's designee to annually notify the students' parents, guardians, or custodians as well as school staff of the schedule of pesticide use on school property and their right to request notification. Such notification shall be made, to the extent possible, at least 72 hours in advance of nonscheduled pesticide use on school property. The notification requirements under this subdivision do not apply to the application of the following types of pesticide products: antimicrobial cleansers, disinfectants, self-contained baits and crack-and-crevice treatments, and any pesticide products classified by the United States Environmental Protection Agency as belonging to the U.S.E.P.A. Toxicity Class IV, "relatively nontoxic" (no signal word required on the product's label).

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(47) To Address Mercury in the Classroom and on School Grounds. – Local boards of education are encouraged to remove and properly dispose of all bulk elemental mercury, chemical mercury, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers. Local boards of education shall prohibit the future use of bulk elemental mercury, chemical mercury compounds,

and bulk mercury compounds used as teaching aids in science classrooms, not including barometers.

(48) To Address Exposure to Diesel Exhaust Fumes. – Local boards of education shall adopt policies and procedures to reduce students' exposure to diesel emissions."

SECTION 3. Nothing in this act shall be construed to create a private cause of action against the State Board of Education, a local board of education, or their agents or employees.

SECTION 4. G.S. 115C-47(45)b., as enacted by Section 2 of this act, becomes effective October 1, 2011. The remainder of this act becomes effective October 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 2059*

Committee Substitute Favorable 6/7/06

Short Title: LTC Fines Posted on Internet. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, TO POST THE FINES AND PENALTIES ASSESSED TO LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Facility Services, shall establish and maintain a list of fines and penalties imposed on nursing homes licensed pursuant to Article 6 of Chapter 131E of the General Statutes, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes, along with a record of fines or payments made pursuant to settlement agreements and the dates such payments were made. The list shall be accessible on the Internet and implemented not later than October 15, 2006. The Department shall report on the implementation of the list to the North Carolina Study Commission on Aging not later than November 1, 2006.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 2059*

Committee Substitute Favorable 6/7/06

PROPOSED SENATE COMMITTEE SUBSTITUTE H2059-CSSQ-66 [v.4]

6/27/2006 11:31:51 AM

Short Title: LTC Fines Posted on Internet. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, TO POST THE VIOLATIONS, FINES AND PENALTIES ASSESSED TO LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Facility Services, shall establish and maintain a list of violations resulting in negative licensure actions, fines and penalties imposed on nursing homes licensed pursuant to Article 6 of Chapter 131E of the General Statutes, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes. The list shall also contain an explanation of the violation; a record of the dates of the violations which resulted in negative licensure actions, fines and penalties; the dates negative actions, fines and penalties were imposed; and a record of the date and amount of fines paid or payments made including payments made pursuant to settlement agreements. The list shall include violations, fines and penalties assessed on and after October 1, 2006, and shall be accessible on the Internet and implemented not later than October 15, 2006. The Department shall report on the implementation of the list to the North Carolina Study Commission on Aging not later than November 1, 2006.

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

HOUSE BILL 2059:
LTC Fines Posted on Internet

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 21, 2006
Introduced by:	Reps. Earle, Weiss, Bordsen	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: ***House Bill 2059 directs the Department of Health and Human Services, Division of Facility Services, to maintain a list on the Internet of violations, fines, penalties, and payments made pursuant to settlement agreements assessed to nursing homes and adult care homes. The bill is a recommendation from the Study Commission on Aging.***

The Senate Proposed Committee Substitute limits the list of violations to those resulting negative licensure action and requires the list to contain an explanation of the violation. The Senate PCS also requires the list to include violations, fines and penalties assessed on and after October 1, 2006.

BILL ANALYSIS:

The Senate PCS to House Bill 2059 implements a recommendation of the Study Commission on Aging, directing the Department of Health and Human Services, Division of Facility Services, to create and maintain a list of the violations resulting in negative licensure action (with explanation), fines and penalties that are assessed to nursing homes licensed under Article 6 of Chapter 131E and that are assessed to adult care homes licensed under Article 1 of Chapter 131D. The bill also requires the Department to list the date those actions were imposed, a record of the date and the amount of the fines or payments made pursuant to settlement agreements and the dates the payments were made.

The bill requires the list be available on the Internet by October 15, 2006 and to include violations, fines and penalties assessed on and after October 1, 2006. The Department is required to report on the implementation of the list to the Study Commission on Aging by November 1, 2006.

The bill becomes effective when it becomes law.

BACKGROUND:

The Study Commission on Aging heard a presentation on March 15, 2006 from the Division of Facility Services that the fines and penalties assessed to long-term care facilities are not currently posted in a location that is accessible to the public.

Currently consumers evaluating nursing homes can access information on the internet regarding nursing homes. The "Nursing Home Compare" on the Medicare website contains information on regulatory requirements that nursing homes failed to meet, but the site does not provide an entire inspection report. According to the website, "a complete inspection report and the nursing home's corresponding plan of correction to address the deficiencies found during the inspection are available from the State survey agency or from the nursing home itself. In addition, each nursing home that provides Medicare or Medicaid services is required to make the results of its last full inspection available onsite for public review." The Nursing Home Compare can be found at: http://www.medicare.gov/NHCompare/home.asp

Information for adult care homes is not readily available. The Commission believes that timely posting the fines and penalties would be valuable resource to consumers.

Theresa Matula contributed to this summary.

H2059e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 2200*

Committee Substitute Favorable 6/20/06

Short Title: Enhance Embargo Auth/Protect Food Supply. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO ENHANCE THE EMBARGO AUTHORITY OF THE SECRETARY OF ENVIRONMENT AND NATURAL RESOURCES AND LOCAL HEALTH DIRECTORS AND TO DIRECT THE DEVELOPMENT OF A STATE PLAN TO PROTECT THE FOOD SUPPLY FROM INTENTIONAL CONTAMINATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-21 reads as rewritten:

"**§ 130A-21. Embargo.**

(a) In addition to the authority of the Department of Agriculture and Consumer Services pursuant to G.S. 106-125, ~~The~~ the Secretary of Environment and Natural Resources ~~and~~ or a local health director has authority to exercise embargo authority concerning food or drink pursuant to G.S. 106-125(a), (b) and (c) when ~~delegated the authority by the Commissioner of Agriculture.~~ the food or drink is in an establishment that is subject to regulation by the Department of Environment and Natural Resources pursuant to this Chapter or that is the subject of an investigation pursuant to G.S. 130A-144; however, no such action shall be taken in any establishment or part of an establishment that is under inspection or otherwise regulated by the Department of Agriculture and Consumer Services or the United States Department of Agriculture other than the part of the establishment that is subject to regulation by the Department of Environment and Natural Resources pursuant to this Chapter. Any action under this section shall only be taken by, or after consultation with, Department of Environment and Natural Resources regional environmental health specialists, or their superiors, in programs regulating food and drink pursuant to this Chapter. Authority under this section shall not be delegated to individual environmental health specialists in local health departments otherwise authorized and carrying out laws and rules pursuant to G.S. 130A-4. When any action is taken pursuant to this section, the Department of Environment and Natural Resources or the local health director shall immediately notify the Department of Agriculture and Consumer Services. For the purposes of this subsection, all duties and procedures in G.S. 106-125 shall be carried out by the

Secretary of the Department of Environment and Natural Resources or the local health director and shall not be required to be carried out by the Department of Agriculture and Consumer Services. It shall be unlawful for any person to remove or dispose of the food or drink by sale or otherwise without the permission of a Department of Environment and Natural Resources regional environmental health specialist or a duly authorized agent of the Department of Agriculture and Consumer Services, or by the court in accordance with the provisions of G.S. 106-125.

(b) If the Secretary of Environment and Natural Resources or a local health director has probable cause to believe that any milk designated as Grade "A" milk is misbranded or does not satisfy the milk sanitation rules adopted pursuant to G.S. 130A-275, the Secretary of Environment and Natural Resources or a local health director may detain or embargo the milk by affixing a tag to it and warning all persons not to remove or dispose of the milk until permission for removal or disposal is given by the official by whom the milk was detained or embargoed or by the court. It shall be unlawful for any person to remove or dispose of the detained or embargoed milk without that permission.

The official by whom the milk was detained or embargoed shall petition a judge of the district or superior court in whose jurisdiction the milk is detained or embargoed for an order for condemnation of the article. If the court finds that the milk is misbranded or that it does not satisfy the milk sanitation rules adopted pursuant to G.S. 130A-275, either the milk shall be destroyed under the supervision of the petitioner or the petitioner shall ensure that the milk will not be used for human consumption as Grade "A" milk. All court costs and fees, storage, expenses of carrying out the court's order and other expense shall be taxed against the claimant of the milk. If, the milk, by proper labelling or processing, can be properly branded and will satisfy the milk sanitation rules adopted pursuant to G.S. 130A-275, the court, after the payment of all costs, fees, and expenses and after the claimant posts an adequate bond, may order that the milk be delivered to the claimant for proper labelling and processing under the supervision of the petitioner. The bond shall be returned to the claimant after the petitioner represents to the court either that the milk is no longer mislabelled or in violation of the milk sanitation rules adopted pursuant to G.S. 130A-275, or that the milk will not be used for human consumption, and that in either case the expenses of supervision have been paid.

(c) If the Secretary of Environment and Natural Resources or a local health director has probable cause to believe that any scallops, shellfish or crustacea is adulterated or misbranded, the Secretary of Environment and Natural Resources or a local health director may detain or embargo the article by affixing a tag to it and warning all persons not to remove or dispose of the article until permission for removal or disposal is given by the official by whom it was detained or embargoed or by the court. It shall be unlawful for any person to remove or dispose of the detained or embargoed article without that permission.

The official by whom the scallops, shellfish or crustacea was detained or embargoed shall petition a judge of the district or superior court in whose jurisdiction the article is detained or embargoed for an order for condemnation of the article. If the court finds that the article is adulterated or misbranded, that article shall be destroyed under the

supervision of the petitioner. All court costs and fees, storage and other expense shall be taxed against the claimant of the article. If, the article, by proper labelling can be properly branded, the court, after the payment of all costs, fees, expenses, and an adequate bond, may order that the article be delivered to the claimant for proper labelling under the supervision of the petitioner. The bond shall be returned to the claimant after the petitioner represents to the court that the article is no longer mislabelled and that the expenses of supervision have been paid.

(d) Nothing in this section is intended to limit the embargo authority of the Department of Agriculture and Consumer Services. The Department of Environment and Natural Resources and the Department of Agriculture and Consumer Services are authorized to enter agreements respecting the duties and responsibilities of each agency in the exercise of their embargo authority.

(e) For the purpose of this section, a food or drink is adulterated if the food or drink is deemed adulterated under G.S. 106-129; and food or drink is misbranded if it is deemed misbranded under G.S. 106-130."

SECTION 2. Article 22 of Chapter 130A of the General Statutes is amended by adding a new section to read:

"**§ 130A-481. Food defense.**

The Department of Agriculture and Consumer Services, Department of Environment and Natural Resources, and Department of Health and Human Services shall jointly develop a plan to protect the food supply from intentional contamination. The plan shall address protection of the food supply from production to consumption, including, but not limited to, the protection of plants, crops, and livestock."

SECTION 3. Section 2 of this act is effective when it becomes law. The remainder of this act becomes effective December 1, 2006, and applies to offenses committed on or after that date.

HOUSE BILL 2200:
Enhance Embargo Auth/Protect Food Supply

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 27, 2006
Introduced by:	Reps. Cunningham, Glazier	**Summary by:**	Ben Popkin
Version:	Second Edition		Committee Counsel

SUMMARY: House Bill 2200 would amend G.S. 130A-21 to authorize the Secretary of Environment and Natural Resources or a local health director to exercise embargo authority concerning food or drink in an establishment subject to regulation by DENR (restaurants and hotels) or subject to an investigation by the local health director in the case of communicable diseases. When such action is taken, the Department of Agriculture and Consumer Services would need to be notified. It would be unlawful to dispose of the embargoed food or drink without proper authority.

(G.S. 130A-25 provides that a violation of Chapter 130A is a misdemeanor. G.S. 14-3 provides that an unclassified misdemeanor is a Class 1 misdemeanor. If no specific punishment is prescribed and the offense is infamous, done in secrecy and malice, or with deceit and intent to defraud, it is a Class H felony.)

The bill would also require the Department of Agriculture and Consumer Services, DENR and DHHS to jointly develop a plan to protect the food supply from intentional contamination.

[As introduced, this bill was identical to S1495, as introduced by Sen. Nesbitt, which is currently in Rules and Operations of the Senate.]

CURRENT LAW: Currently, G.S. 130A-21 authorizes DENR and local health directors to exercise embargo authority when the authority is delegated by the Commissioner of Agriculture.

EFFECTIVE DATE: The act would be effective December 1, 2006 and would apply to offenses committed on or after that date.

BACKGROUND: This bill was recommended by the Joint Study Committee on Emergency Preparedness and Disaster Management Recovery.

Steve Rose, counsel to House Judiciary IV, substantially contributed to this summary.

H2200e2-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 1301

Committee Substitute Favorable 5/17/05

Short Title: Physical Therapy Bd./Competency of Licensees. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHYSICAL THERAPY EXAMINERS TO REQUIRE LICENSEES TO DEMONSTRATE CONTINUING COMPETENCE IN THE PRACTICE OF PHYSICAL THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.26 is amended by adding the following new subdivision to read:

"**§ 90-270.26. Powers of the Board.**

The Board shall have the following general powers and duties:

...

(3a) Establish mechanisms for assessing the continuing competence of licensed physical therapists or physical therapist assistants to engage in the practice of physical therapy, including approving rules requiring licensees to periodically, or in response to complaints or incident reports, submit to the Board: (i) evidence of continuing education experiences; (ii) evidence of minimum standard accomplishments; or (iii) evidence of compliance with other Board-approved measures, audits, or evaluations; and specify remedial actions if necessary or desirable to obtain license renewal or reinstatement;

...."

SECTION 2. G.S. 90-270.32 reads as rewritten:

"**§ 90-270.32. Renewal of license; lapse; revival.**

(a) Every licensed physical therapist or physical therapist assistant shall, during the month of January of every year, apply to the Board for a renewal of licensure and pay to the secretary-treasurer the prescribed fee. Licenses that are not so renewed shall automatically lapse. The Board may decline to renew licenses of physical therapists or physical therapist assistants for failure to comply with any required continuing competency measures.

(b) The manner in which lapsed licenses shall be ~~revived~~ revived, reinstated, or extended shall be established by the Board in its discretion."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1301

Committee Substitute Favorable 5/17/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H1301-PCS50748-LB-137

Short Title: Physical Therapy Bd./Competency of Licensees. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHYSICAL THERAPY EXAMINERS TO REQUIRE LICENSEES TO DEMONSTRATE CONTINUING COMPETENCE IN THE PRACTICE OF PHYSICAL THERAPY.

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physical therapist assistants for failure to comply with any required continuing competency measures.

(b) The manner in which lapsed licenses shall be ~~revived~~ revived, reinstated, or extended shall be established by the Board in its discretion."

SECTION 3. G.S. 55B-14(c) is amended by adding the following new subdivision to read:

"(9) A physician practicing orthopedics and a podiatrist who is licensed under Article 12A of Chapter 90 of the General Statutes to render either or both of orthopedic services and podiatric and related services that the respective stockholders are licensed, certified, or otherwise approved to provide."

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

HOUSE BILL 1301:
Physical Therapy Bd./Competency of Licensees

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 28, 2006
Introduced by:	Rep. L. Allen	**Summary by:**	Shawn Parker
Version:	PCS to Second Edition H1301-CSLB-137		Legislative Analyst

SUMMARY: ***House Bill 1301 would authorize the North Carolina Board of Physical Therapy Examiners to require, as part of the license renewal process, continuing education experiences, minimum standard accomplishments, or compliance with other measures periodically or in response to complaints or incident reports.***

The Senate Proposed Committee Substitute allows an entity including a physician practicing orthopedics and a licensed podiatrist to form a professional corporation.

CURRENT LAW: Article 18B of Chapter 90 in the General Statutes regulates the practice of Physical Therapy in North Carolina. The North Carolina Board of Physical Therapy Examiners is the enabling body designated to safeguard public health, safety and welfare against unqualified or incompetent practitioners. Under current law, every licensed physical therapist or physical therapist assistant must annually, during the month of January, apply to the Board for a renewal of licensure and must also pay the appropriate established fee.

BILL ANALYSIS:

Section 1 authorizes the Board of Physical Therapy Examiners to approve rules establishing mechanisms for assessing the continuing competences of licensed physical therapist and licensed physical therapist assistants. The bill further authorizes the Board to require periodically, or in response to complaints or incident reports, licensees to submit evidence of:

- Continuing education experiences.
- Minimum standard accomplishments.
- Compliance with other Board-approved measures, audits or evaluations.

Section 2 authorizes the Board to decline to renew licenses for failure to comply with any required continuing competency measures.

Section 3 would allow an entity comprised of a physician practicing orthopedics and a licensed podiatrist to form a professional corporation.

EFFECTIVE DATE: The act would become effective when it becomes law.

BACKGROUND: The North Carolina Board of Physical Therapy Examiners was created in 1951 by the General Assembly to establish and maintain minimum standards for the practice of physical therapy to protect the safety and welfare of the citizens of North Carolina; to license physical therapists and physical therapist assistants to practice physical therapy in the State; to investigate complaints regarding unauthorized practice of physical therapy in the State and acts of licensees that violate the Practice Act and to issue interpretation of questions arising from the Physical Therapy Practice Act.[1]

H1301e2-SMSQ-CSLB-137

[1] Source- http://www.ncptboard.org

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1301

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

H1301-ASQ-33 [v.1]

Date ,2006

Comm. Sub. [NO]
Amends Title [YES]
Second Edition

Senator Purcell

moves to amend the bill on page 1, line 4 by rewriting the line to read:
"CONTINUING COMPETENCE IN THE PRACTICE OF PHYSICAL THERAPY AND TO ALLOW CERTAIN GROUPS TO PRACTICE AS PROFESSIONAL CORPORATIONS.".

X SIGNED
Amendment Sponsor

SIGNED
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED TABLED

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1301

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

H1301-ASQ-34 [v.1]

Date _____,2006

Comm. Sub. [YES]
Amends Title [YES]
H1301-PCS50748-LB-137

Senator Purcell

moves to amend the bill on page 2, line 12, by deleting the line and substituting the following:

"**SECTION 4.** G.S. 90-14 reads as rewritten:

"**§ 90-14. Revocation, suspension, annulment or denial of license.**

(a) The Board shall have the power to place on probation with or without conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of

the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The Board shall not revoke the license of or deny a license to a person solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, ~~by members of the Board or by other physicians licensed to practice medicine in this State,~~ as the Board

deems necessary to determine the professional qualifications of such licensee. In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find by the greater weight of the evidence that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(11a) Not actively practiced medicine or practiced as a physician assistant, or having not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for an initial license from the Board or a request, petition, motion, or application to reactivate an inactive, suspended, or revoked license previously issued by the Board. The Board is authorized to adopt any rules or regulations it deems necessary to carry out the provisions of this subdivision.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

~~For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable.~~ The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or ~~rescinded,~~otherwise acted upon, except that no license that has been revoked shall be restored for a period of two years following the date of revocation.

(b) The Board shall refer to the ~~State Medical Society Physician Health and Effectiveness Committee~~ North Carolina Physicians Health Program all physicians and physician assistants whose health and effectiveness have been significantly impaired by alcohol, drug addiction or mental illness. Sexual misconduct shall not constitute mental illness for purposes of this subsection.

(c) A felony conviction shall result in the automatic revocation of a license issued by the Board, unless the Board orders otherwise or receives a request for a hearing from the person within 60 days of receiving notice from the Board, after the conviction, of the provisions of this subsection. If the Board receives a timely request for a hearing in such a case, the provisions of G.S. 90-14.2 shall be followed.

~~(d) The Board and its members and staff may release confidential or nonpublic information to any health care licensure board in this State or another state about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a Board licensed physician, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the physician within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the physician. If the physician requests, in writing, within 30 days after being notified that such information has been transmitted, he shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law enforcement agency, or authorized Department of~~

~~Health and Human Services personnel with enforcement or investigative responsibilities.~~

(d) The Board and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law.

(e) A person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice shall be immune from civil liability for (i) ~~reporting or~~ reporting, investigating, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice medicine and (ii) initiating or conducting proceedings against a licensee or applicant if a complaint is made or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice medicine, or for making a recommendation to the Board in the nature of peer review, in good faith and without fraud and malice.

(f) Prior to taking action against any licensee who practices integrative medicine for providing care not in accordance with the standards of practice for the procedures or treatments administered, the Board shall consult with a licensee who practices integrative medicine."

SECTION 5. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of ~~trial examiner or~~hearing committee and depositions.**

~~Where the licensee requests that the hearing herein provided for be held by the Board in a county other than the county designated for the holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose~~

~~or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court.~~

(a) The Board, in its discretion, may designate in writing three or more of its members to conduct hearings as a hearing committee to take evidence.

(b) Evidence and testimony may be presented at hearings before the Board or a hearing committee in the form of depositions before any person authorized to administer oaths in accordance with the procedure for the taking of depositions in civil actions in the superior court.

(c) The hearing committee shall submit a recommended decision that contains findings of fact and conclusions of law to the Board. Before the Board makes a final decision, it shall give each party an opportunity to file written exceptions to the recommended decision made by the hearing committee and to present oral arguments to the Board. A quorum of the Board will issue a final decision."

SECTION 6. G.S. 90-14.13 reads as rewritten:

"**§ 90-14.13. Reports of disciplinary action by health care institutions; reports of professional liability insurance awards or settlements; immunity from liability.**

(a) The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in G.S. 58-50-56, and all other provider organizations that issue credentials to physicians who practice medicine in the State, shall, after consultation with the chief of staff of that institution, report to the Board ~~any revocation, suspension, or limitation of~~ the following actions involving a physician's privileges to practice in that ~~institution.~~institution within 30 days, of the date that the action takes effect:

(1) A summary revocation, summary suspension, or summary limitation of privileges, regardless of whether the action has been finally determined.

(2) A revocation, suspension, or limitation of privileges that has been finally determined by the governing body of the institution.

(3) A resignation from practice or voluntary reduction of privileges.

(4) Any action reportable pursuant to Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended, not otherwise reportable under subdivisions (1), (2), or (3) of this subsection.

(a1) A hospital is not required to ~~report the~~ report:

(1) The suspension or limitation of a physician's privileges for failure to timely complete medical records unless the suspension or limitation is the third within the calendar year for failure to timely complete medical records. Upon reporting the third suspension or limitation, the hospital shall also report the previous two ~~suspensions.~~suspensions or limitations. ~~The institution shall also report to the Board resignations from practice in that institution by persons licensed under this Article.~~

(2) A resignation from practice due solely to the physician's completion of a medical residency, internship, or fellowship.

(a2) The Board shall report all violations of ~~this~~ subsection (a) of this section known to it to the licensing agency for the institution involved. The licensing agency for the institution involved is authorized to order the payment of a civil penalty of two hundred and fifty dollars ($250) for a first violation and five hundred dollars ($500) for each subsequent violation if the institution fails to report as required under subsection (a) of this section.

(b) Any licensed physician who does not possess professional liability insurance shall report to the Board any award of damages or any settlement of any malpractice complaint affecting his or her practice within 30 days of the award or settlement.

(c) The chief administrative officer of each insurance company providing professional liability insurance for physicians who practice medicine in North Carolina, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund or other fund operated or administered by a hospital authority, group, or provider shall report to the Board within 30 ~~days:~~days any of the following:

(1) Any award of damages or settlement of any claim or lawsuit affecting or involving the ~~physician~~ a person licensed under this Article that it ~~insures, or~~insures.

(2) Any cancellation or nonrenewal of its professional liability coverage of a physician, if the cancellation or nonrenewal was for cause.

(3) A malpractice payment that is reportable pursuant to Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended, not otherwise reportable under subdivisions (1) or (2) of this subsection.

(d) ~~The Board may request details about any action and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public.~~ The Board shall report all violations of this ~~paragraph~~ section to the Commissioner of Insurance. The Commissioner of Insurance is authorized to order the payment of a civil penalty of two hundred fifty dollars ($250) for a first violation and five hundred dollars ($500.00) for each subsequent violation against an insurer for failure to report as required under this section.

(e) The Board may request details about any action covered by this section, and the licensees or officers shall promptly furnish the requested information. The reports required by this section are privileged, not open to the public, confidential and are not subject to discovery, subpoena, or other means of legal compulsion for release to anyone other than the Board or its employees or agents involved in application for license or discipline, except as provided in G.S. 90-16. Any ~~person~~officer making a report required by this section, providing additional information required by the Board, or testifying in any proceeding as a result of the report or required information shall be immune from any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in reckless disregard of whether the report was false."

SECTION 7. G.S. 90-16 reads as rewritten:

"**§ 90-16. Self-reporting requirements; confidentiality of Board investigative information; cooperation with law enforcement; patient protection; Board to keep public records. ~~record; publication of names of licentiates; transcript as evidence; receipt of evidence concerning treatment of patient who has not consented to public disclosure.~~**

(a) The North Carolina Medical Board shall keep a regular record of its proceedings in a book kept for that purpose, together with the names of the members of the Board present, the names of the applicants for license, and other information as to its actions. The North Carolina Medical Board shall cause to be entered in a separate book

the name of each applicant to whom a license is issued to practice medicine or surgery, along with any information pertinent to such issuance. The North Carolina Medical Board shall publish the names of those licensed in three daily newspapers published in the State of North Carolina, within 30 days after granting the same. A transcript of any such entry in the record books, or certificate that there is not entered therein the name and proficiency or date of granting such license of a person charged with the violation of the provisions of this Article, certified under the hand of the secretary and the seals of the North Carolina Medical Board, shall be admitted as evidence in any court of this State when it is otherwise competent.

(b) The Board may in a closed session receive evidence involving or concerning the treatment of a patient who has not expressly or impliedly consented to the public disclosure of such treatment as may be necessary for the protection of the rights of such patient or of the accused physician and the full presentation of relevant evidence.

(c) All records, papers, investigative files, investigative reports, other investigative information and other documents containing information in the possession of or received or gathered, ~~collected and compiled~~ by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, ~~or~~complaint or, disciplinary ~~matter~~ matter, or report of professional liability insurance awards or settlements pursuant to G.S. 90-14.13, shall not be considered public records within the meaning of Chapter 132 of the General ~~Statutes; provided, however, that any~~ Statutes and are privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than the Board, its employees or agents involved in the application for license or discipline of a license holder, except as provided in subsection (d) of this section. For purposes of this subsection, investigative information includes information relating to the identity of, and a report made by, a physician or other person performing an expert review for the Board.

(d) The Board shall provide the licensee or applicant with access to all information in its possession that the Board intends to offer into evidence in presenting its case in chief at the contested hearing on the matter, subject to any privilege or restriction set forth by rule, statute, or legal precedent, upon written request from a licensee or applicant who is the subject of a complaint or investigation, or from the

licensee's or applicant's counsel, unless good cause is shown for delay. The Board is not required to provide any of the following:

(1) A Board investigative report.

(2) The identity of a non-testifying complainant.

(3) Attorney-client communications, attorney work product, or other materials covered by a privilege recognized by the Rules of Civil Procedure or the Rules of Evidence.

(e) Information furnished to a licensee or applicant, or counsel for a licensee or applicant, under subsection (d) of this section shall be subject to discovery or subpoena between and among the parties in a civil case in which the licensee is a party.

(f) Any notice or statement of charges against any licensee, or any notice to any licensee of a hearing in any proceeding shall be a public record within the meaning of Chapter 132 of the General Statutes, notwithstanding that it may contain information collected and compiled as a result of any such investigation, inquiry or interview; and provided, further, that if any such record, paper or other document containing information theretofore collected and compiled by the Board, as hereinbefore provided, is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record within the meaning of Chapter 132 of the General Statutes.

(g) In any proceeding before the Board, in any record of any hearing before the Board, and in the notice of the charges against any licensee (notwithstanding any provision herein to the contrary) the Board may withhold from public disclosure the identity of a patient who has not expressly or impliedly consented to the public disclosure of treatment by the accused physician.

(h) If investigative information in the possession of the Board, its employees or agents indicates that a crime may have been committed, the Board shall report the information to the appropriate law enforcement agency.

(i) The Board shall cooperate with and assist a law enforcement agency conducting a criminal investigation of a licensee by providing information that is relevant to the criminal investigation to the investigating agency. Information disclosed by the Board to an investigative agency remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation.

(j) All persons licensed under this Article shall self-report to the Board within thirty (30) days of arrest or indictment any of the following:

(1) Any felony arrest or indictment.
(2) Any arrest for driving while impaired or driving under the influence.
(3) Any arrest or indictment for the possession, use, or sale of any controlled substance.

(k) The Board, its members and staff, may release confidential or nonpublic information to any health care licensure board in this State or another state about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a licensee of the Board, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the licensee within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the licensee. If the licensee requests in writing within 30 days after being notified that the information has been transmitted, the licensee shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law-enforcement agency, or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities."

SECTION 8. G.S. 90-21.22(d) reads as rewritten:

"(d) Upon investigation and review of a physician licensed by the Board, or a physician assistant approved by the Board, or upon receipt of a complaint or other information, a society which enters a peer review agreement with the Board, or the Academy if it has a peer review agreement with the Board, as appropriate, shall report immediately to the Board detailed information about any physician or physician assistant licensed or approved by the Board if:

(1) The physician or physician assistant constitutes an imminent danger to the public or to himself by reason of impairment, mental illness, physical illness, the commission of professional sexual boundary violations, or any other reason;
(2) The physician or physician assistant refuses to cooperate with the program, refuses to submit to treatment, or is still impaired after treatment and exhibits professional incompetence; or
(3) It reasonably appears that there are other grounds for disciplinary action."

SECTION 9. G.S. 131E-87 reads as rewritten:

"**§ 131E-87. Reports of disciplinary action; immunity from liability.**

The chief administrative officer of each licensed hospital in the State shall report to the appropriate occupational licensing board the details, as prescribed by the board, of any revocation, suspension, ~~or limitation~~limitation, or voluntary reduction of privileges of a health care provider to practice in that hospital. Each hospital shall also report to the board its medical staff resignations. Reports concerning physician privileges and resignations shall be made in accordance with G.S. 90-14.13. Any person making a report required by this section shall be immune from any resulting criminal prosecution or civil liability unless the person knew the report was false or acted in reckless disregard of whether the report was false."

SECTION 10.(a) The subcommittee of the North Carolina Medical Board and the subcommittee of the Board of Nursing, directed to work jointly to develop rules to govern the performance of medical acts by registered nurses pursuant to G.S. 90-6(b), shall examine adding the provisions of G.S. 90-14(a) to their joint rules that set forth grounds for action against a registered nurse's approval to perform medical acts.

SECTION 10.(b) The subcommittee of the North Carolina Medical Board and the subcommittee of the North Carolina Board of Pharmacy, directed to work jointly to develop rules to govern the performance of medical acts by clinical pharmacist practitioners pursuant to G.S. 90-6(c), shall examine adding the provisions of G.S. 90-14(a) to the joint rules that set forth grounds for action against a clinical pharmacist practitioner's approval to perform medical acts.

SECTION 10.(c) The North Carolina Medical Board, the Board of Nursing, and the North Carolina Pharmacy Board shall report to the Chairs of the House Committee on Health, the Senate Committee on Health Care, the House Select Committee on Health Care, and the Subcommittee on Patient Safety, Quality and Accountability of the House Select Committee on Health Care on the adoption of the provisions of G.S. 90-14(a) as part of the joint rules governing the practice of medical acts for nurse practitioners and clinical pharmacist practitioners. The boards shall file their reports no later than September 1, 2006.

SECTION 10.(d) The North Carolina Medical Board shall examine the provisions of G.S. 90-14.13 and may develop policies or guidance governing the reporting requirements of that section. The Medical Board may recommend additional

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1301

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

H1301-ASQ-34 [v.1]

legislation, if necessary, to implement these policies, prior to the convening of the 2007 General Assembly.

SECTION 11. Sections 4, through 9 of this act are effective October 1, 2006. The remainder of this act becomes effective when this act becomes law. Section 4 applies to acts or omissions that occur on or after the effective date. Section 5 applies to hearings held on or after the effective date. Section 6 applies to awards entered or settlements entered into on or after the effective date.".

SIGNED William D Pruett
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. _____ DATE 6-28

S. B. No. _____ Amendment No. _____ (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE PCS-50748-LB137

Rep.) Parfitt Nesbitt

Sen.)

1 moves to amend the bill on page 1, line 4

2 (X) WHICH CHANGES THE TITLE

3 by deleting the word "THERAPY." and

4 substituting the phrase "THERAPY, AND

5 TO STRENGTHEN THE AUTHORITY OF THE NORTH

6 CAROLINA MEDICAL BOARD TO DISCIPLINE

7 PHYSICIANS AND CERTAIN OTHERS."

8

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SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1301

AMENDMENT NO. 4
(to be filled in by Principal Clerk)

H1301-ARD-45 [v.1]

Date _____,2006

Comm. Sub. [YES]
Amends Title [YES]
Second Edition

Senator Purcell

moves to amend the bill on page 1, line 4, by deleting the word "~~THERAPY~~." and substituting the phrase "THERAPY, AND DESIGNATING INFORMATION RELEASED TO PATIENT SAFETY ORGANIZATIONS AS CONFIDENTIAL."; and on page 2, lines 11-12, by adding between the lines a new section to read:

"**SECTION 3.1.** G.S. 131E-95(c) reads as rewritten:

'(c) Information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional standards review organization that performs any accreditation or certification including the Joint Commission on Accreditation of Healthcare~~ Organizations.~~ Organizations, or to a patient safety organization or its designated contractors. Information released under this 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.~~ certification, or the patient safety organization's or its contractors' analysis of patient safety and healthcare quality. Information released under this subsection retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this section, and the standards review or patient safety organization shall keep the information confidential subject to this ~~section.~~ Section, except as necessary to carry out the organization's patient safety, accreditation, or certification activities. For the purposes of this section, 'patient safety organization' means an entity that collects and analyzes patient safety or healthcare quality data of providers for the purpose of improving patient safety and the quality of health care delivery and includes, but is not limited to, an entity formed pursuant to Public Law No. 109-41.'".

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1301

Committee Substitute Favorable 5/17/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H1301-PCS50752-SQ-71

Short Title: PT Bd. Lic/Strngth Bd. Med/Patient Safe Org. (Public)

Sponsors:

Referred to:

April 20, 2005

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHYSICAL THERAPY EXAMINERS TO REQUIRE LICENSEES TO DEMONSTRATE CONTINUING COMPETENCE IN THE PRACTICE OF PHYSICAL THERAPY, AND STRENGTHENING THE AUTHORITY OF THE NORTH CAROLINA MEDICAL BOARD TO DISCIPLINE PHYSICIANS AND CERTAIN OTHERS, AND DESIGNATING INFORMATION RELEASED TO PATIENT SAFETY ORGANIZATIONS AS CONFIDENTIAL, AND ALLOWING CERTAIN GROUPS TO PRACTICE AS PROFESSIONAL CORPORATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.26 is amended by adding the following new subdivision to read:

"**§ 90-270.26. Powers of the Board.**

The Board shall have the following general powers and duties:

...

(3a) Establish mechanisms for assessing the continuing competence of licensed physical therapists or physical therapist assistants to engage in the practice of physical therapy, including approving rules requiring licensees to periodically, or in response to complaints or incident reports, submit to the Board: (i) evidence of continuing education experiences; (ii) evidence of minimum standard accomplishments; or (iii) evidence of compliance with other Board-approved measures, audits, or evaluations; and specify remedial actions if necessary or desirable to obtain license renewal or reinstatement;

...."

SECTION 2. G.S. 90-270.32 reads as rewritten:

"**§ 90-270.32. Renewal of license; lapse; revival.**

(a) Every licensed physical therapist or physical therapist assistant shall, during the month of January of every year, apply to the Board for a renewal of licensure and pay to the secretary-treasurer the prescribed fee. Licenses that are not so renewed shall automatically lapse. The Board may decline to renew licenses of physical therapists or physical therapist assistants for failure to comply with any required continuing competency measures.

(b) The manner in which lapsed licenses shall be ~~revived~~ revived, reinstated, or extended shall be established by the Board in its discretion."

SECTION 3.1. G.S. 55B-14(c) is amended by adding the following new subdivision to read:

"(9) A physician practicing orthopedics and a podiatrist who is licensed under Article 12A of Chapter 90 of the General Statutes to render either or both of orthopedic services and podiatric and related services that the respective stockholders are licensed, certified, or otherwise approved to provide."

SECTION 3.2. G.S. 131E-95(c) reads as rewritten:

"(c) Information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional standards review organization that performs any accreditation or certification including the Joint Commission on Accreditation of Healthcare ~~Organizations.~~ Organizations, or to a patient safety organization or its designated contractors. Information released under this 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.~~ certification, or the patient safety organization's or its contractors' analysis of patient safety and health care quality. Information released under this subsection retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this section, and the standards review or patient safety organization shall keep the information confidential subject to this ~~section.~~ section, except as necessary to carry out the organization's patient safety, accreditation, or certification activities. For the purposes of this section, 'patient safety organization' means an entity that collects and analyzes patient safety or health care quality data of providers for the purpose of improving patient safety and the quality of health care delivery and includes, but is not limited to, an entity formed pursuant to Public Law No. 109-41."

SECTION 4. G.S. 90-14 reads as rewritten:

"**§ 90-14. Revocation, suspension, annulment or denial of license.**

(a) The Board shall have the power to place on probation with or without conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The Board shall not revoke the license of or deny a license to a person solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, ~~by members of the Board or by other physicians licensed to practice medicine in this State,~~ as the Board

deems necessary to determine the professional qualifications of such licensee. In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find by the greater weight of the evidence that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(11a) Not actively practiced medicine or practiced as a physician assistant, or having not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for an initial license from the Board or a request, petition, motion, or application to reactivate an inactive, suspended, or revoked license previously issued by the Board. The Board is authorized to adopt any rules or regulations it deems necessary to carry out the provisions of this subdivision.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

~~For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant or revoke a license issued to a physician, may suspend such a license for a period of time, and may impose conditions upon the continued practice after such period of suspension as the Board may deem advisable, may limit the accused physician's practice of medicine with respect to the extent, nature or location of the physician's practice as the Board deems advisable.~~ The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so

revoked or ~~rescinded,~~otherwise acted upon, except that no license that has been revoked shall be restored for a period of two years following the date of revocation.

(b) The Board shall refer to the ~~State Medical Society Physician Health and Effectiveness Committee~~ North Carolina Physicians Health Program all physicians and physician assistants whose health and effectiveness have been significantly impaired by alcohol, drug addiction or mental illness. Sexual misconduct shall not constitute mental illness for purposes of this subsection.

(c) A felony conviction shall result in the automatic revocation of a license issued by the Board, unless the Board orders otherwise or receives a request for a hearing from the person within 60 days of receiving notice from the Board, after the conviction, of the provisions of this subsection. If the Board receives a timely request for a hearing in such a case, the provisions of G.S. 90-14.2 shall be followed.

~~(d) The Board and its members and staff may release confidential or nonpublic information to any health care licensure board in this State or another state about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a Board-licensed physician, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the physician within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the physician. If the physician requests, in writing, within 30 days after being notified that such information has been transmitted, he shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law enforcement agency, or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities.~~

(e) The Board and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law.

(f) A person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice shall be immune from civil liability for (i) ~~reporting or~~ reporting, investigating, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice medicine and (ii) initiating or conducting proceedings against a licensee or applicant if a complaint is made or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice medicine, or for making a recommendation to the Board in the nature of peer review, in good faith and without fraud and malice.

(g) Prior to taking action against any licensee who practices integrative medicine for providing care not in accordance with the standards of practice for the procedures or

treatments administered, the Board shall consult with a licensee who practices integrative medicine."

SECTION 5. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of ~~trial examiner or~~hearing committee and depositions.**

~~Where the licensee requests that the hearing herein provided for be held by the Board in a county other than the county designated for the holding of the meeting of the Board at which the matter is to be heard, the Board may designate in writing one or more of its members to conduct the hearing as a trial examiner or trial committee, to take evidence and report a written transcript thereof to the Board at a meeting where a majority of the members are present and participating in the decision. Evidence and testimony may also be presented at such hearings and to the Board in the form of depositions taken before any person designated in writing by the Board for such purpose or before any person authorized to administer oaths, in accordance with the procedure for the taking of depositions in civil actions in the superior court.~~

(a) The Board, in its discretion, may designate in writing three or more of its members to conduct hearings as a hearing committee to take evidence.

(b) Evidence and testimony may be presented at hearings before the Board or a hearing committee in the form of depositions before any person authorized to administer oaths in accordance with the procedure for the taking of depositions in civil actions in the superior court.

(c) The hearing committee shall submit a recommended decision that contains findings of fact and conclusions of law to the Board. Before the Board makes a final decision, it shall give each party an opportunity to file written exceptions to the recommended decision made by the hearing committee and to present oral arguments to the Board. A quorum of the Board will issue a final decision."

SECTION 6. G.S. 90-14.13 reads as rewritten:

"**§ 90-14.13. Reports of disciplinary action by health care institutions; reports of professional liability insurance awards or settlements; immunity from liability.**

(a) The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in G.S. 58-50-56, and all other provider organizations that issue credentials to physicians who practice medicine in the State, shall, after consultation with the chief of staff of that institution, report to the Board ~~any revocation, suspension, or limitation of~~ the following actions involving a physician's privileges to practice in that ~~institution.~~institution within 30 days of the date that the action takes effect:

(1) A summary revocation, summary suspension, or summary limitation of privileges, regardless of whether the action has been finally determined.

(2) A revocation, suspension, or limitation of privileges that has been finally determined by the governing body of the institution.

(3) A resignation from practice or voluntary reduction of privileges.

(4) Any action reportable pursuant to Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended, not otherwise reportable under subdivisions (1), (2), or (3) of this subsection.

(a1) A hospital is not required to ~~report the~~ report:

(1) The suspension or limitation of a physician's privileges for failure to timely complete medical records unless the suspension or limitation is the third within the calendar year for failure to timely complete medical records. Upon reporting the third suspension or limitation, the hospital shall also report the previous two ~~suspensions.~~suspensions or limitations. ~~The institution shall also report to the Board resignations from practice in that institution by persons licensed under this Article.~~

(2) A resignation from practice due solely to the physician's completion of a medical residency, internship, or fellowship.

(a2) The Board shall report all violations of ~~this~~ subsection (a) of this section known to it to the licensing agency for the institution involved. The licensing agency for the institution involved is authorized to order the payment of a civil penalty of two hundred fifty dollars ($250.00) for a first violation and five hundred dollars ($500.00) for each subsequent violation if the institution fails to report as required under subsection (a) of this section.

(b) Any licensed physician who does not possess professional liability insurance shall report to the Board any award of damages or any settlement of any malpractice complaint affecting his or her practice within 30 days of the award or settlement.

(c) The chief administrative officer of each insurance company providing professional liability insurance for physicians who practice medicine in North Carolina, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund or other fund operated or administered by a hospital authority, group, or provider shall report to the Board within 30 ~~days:~~days any of the following:

(1) Any award of damages or settlement of any claim or lawsuit affecting or involving ~~the physician~~ a person licensed under this Article that it ~~insures, or~~insures.

(2) Any cancellation or nonrenewal of its professional liability coverage of a physician, if the cancellation or nonrenewal was for cause.

(3) A malpractice payment that is reportable pursuant to Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended, not otherwise reportable under subdivision (1) or (2) of this subsection.

(d) ~~The Board may request details about any action and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public.~~ The Board shall report all violations of this ~~paragraph~~ section to the Commissioner of Insurance. The Commissioner of Insurance is authorized to order the payment of a civil penalty of two hundred fifty dollars ($250.00) for a first violation and five hundred dollars ($500.00) for each

subsequent violation against an insurer for failure to report as required under this section.

(e) The Board may request details about any action covered by this section, and the licensees or officers shall promptly furnish the requested information. The reports required by this section are privileged, not open to the public, confidential and are not subject to discovery, subpoena, or other means of legal compulsion for release to anyone other than the Board or its employees or agents involved in application for license or discipline, except as provided in G.S. 90-16. Any ~~person~~officer making a report required by this section, providing additional information required by the Board, or testifying in any proceeding as a result of the report or required information shall be immune from any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in reckless disregard of whether the report was false."

SECTION 7. G.S. 90-16 reads as rewritten:

"**§ 90-16. Self-reporting requirements; confidentiality of Board investigative information; cooperation with law enforcement; patient protection; Board to keep public records.** ~~**record; publication of names of licentiates; transcript as evidence; receipt of evidence concerning treatment of patient who has not consented to public disclosure.**~~

(a) The North Carolina Medical Board shall keep a regular record of its proceedings in a book kept for that purpose, together with the names of the members of the Board present, the names of the applicants for license, and other information as to its actions. The North Carolina Medical Board shall cause to be entered in a separate book the name of each applicant to whom a license is issued to practice medicine or surgery, along with any information pertinent to such issuance. The North Carolina Medical Board shall publish the names of those licensed in three daily newspapers published in the State of North Carolina, within 30 days after granting the same. A transcript of any such entry in the record books, or certificate that there is not entered therein the name and proficiency or date of granting such license of a person charged with the violation of the provisions of this Article, certified under the hand of the secretary and the seals of the North Carolina Medical Board, shall be admitted as evidence in any court of this State when it is otherwise competent.

(b) The Board may in a closed session receive evidence involving or concerning the treatment of a patient who has not expressly or impliedly consented to the public disclosure of such treatment as may be necessary for the protection of the rights of such patient or of the accused physician and the full presentation of relevant evidence.

(c) All records, papers, investigative files, investigative reports, other investigative information and other documents containing information in the possession of or received or gathered ~~collected and compiled~~ by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, ~~or~~complaint or, disciplinary ~~matter~~ matter, or report of professional liability insurance awards or settlements pursuant to G.S. 90-14.13, shall not be considered public records within the meaning of Chapter 132 of the General ~~Statutes; provided, however, that any~~ Statutes and are privileged, confidential, and not subject to

discovery, subpoena, or other means of legal compulsion for release to any person other than the Board, its employees or agents involved in the application for license or discipline of a license holder, except as provided in subsection (d) of this section. For purposes of this subsection, investigative information includes information relating to the identity of, and a report made by, a physician or other person performing an expert review for the Board.

(d) The Board shall provide the licensee or applicant with access to all information in its possession that the Board intends to offer into evidence in presenting its case in chief at the contested hearing on the matter, subject to any privilege or restriction set forth by rule, statute, or legal precedent, upon written request from a licensee or applicant who is the subject of a complaint or investigation, or from the licensee's or applicant's counsel, unless good cause is shown for delay. The Board is not required to provide any of the following:

(1) A Board investigative report.

(2) The identity of a non-testifying complainant.

(3) Attorney-client communications, attorney work product, or other materials covered by a privilege recognized by the Rules of Civil Procedure or the Rules of Evidence.

(e) Information furnished to a licensee or applicant, or counsel for a licensee or applicant, under subsection (d) of this section shall be subject to discovery or subpoena between and among the parties in a civil case in which the licensee is a party.

(f) Any notice or statement of charges against any licensee, or any notice to any licensee of a hearing in any proceeding shall be a public record within the meaning of Chapter 132 of the General Statutes, notwithstanding that it may contain information collected and compiled as a result of any such investigation, inquiry or interview; and provided, further, that if any such record, paper or other document containing information theretofore collected and compiled by the Board, as hereinbefore provided, is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record within the meaning of Chapter 132 of the General Statutes.

(g) In any proceeding before the Board, in any record of any hearing before the Board, and in the notice of the charges against any licensee (notwithstanding any provision herein to the contrary) the Board may withhold from public disclosure the identity of a patient who has not expressly or impliedly consented to the public disclosure of treatment by the accused physician.

(h) If investigative information in the possession of the Board, its employees, or agents indicates that a crime may have been committed, the Board shall report the information to the appropriate law enforcement agency.

(i) The Board shall cooperate with and assist a law enforcement agency conducting a criminal investigation of a licensee by providing information that is relevant to the criminal investigation to the investigating agency. Information disclosed by the Board to an investigative agency remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation.

(j) All persons licensed under this Article shall self-report to the Board within 30 days of arrest or indictment any of the following:

(1) Any felony arrest or indictment.
(2) Any arrest for driving while impaired or driving under the influence.
(3) Any arrest or indictment for the possession, use, or sale of any controlled substance.

(k) The Board, its members and staff, may release confidential or nonpublic information to any health care licensure board in this State or another state about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a licensee of the Board, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the licensee within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the licensee. If the licensee requests in writing within 30 days after being notified that the information has been transmitted, the licensee shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law enforcement agency or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities."

SECTION 8. G.S. 90-21.22(d) reads as rewritten:

"(d) Upon investigation and review of a physician licensed by the Board, or a physician assistant approved by the Board, or upon receipt of a complaint or other information, a society which enters a peer review agreement with the Board, or the Academy if it has a peer review agreement with the Board, as appropriate, shall report immediately to the Board detailed information about any physician or physician assistant licensed or approved by the Board if:

(1) The physician or physician assistant constitutes an imminent danger to the public or to himself by reason of impairment, mental illness, physical illness, the commission of professional sexual boundary violations, or any other reason;
(2) The physician or physician assistant refuses to cooperate with the program, refuses to submit to treatment, or is still impaired after treatment and exhibits professional incompetence; or
(3) It reasonably appears that there are other grounds for disciplinary action."

SECTION 9. G.S. 131E-87 reads as rewritten:

"**§ 131E-87. Reports of disciplinary action; immunity from liability.**

The chief administrative officer of each licensed hospital in the State shall report to the appropriate occupational licensing board the details, as prescribed by the board, of any revocation, suspension, ~~or limitation~~limitation, or voluntary reduction of privileges of a health care provider to practice in that hospital. Each hospital shall also report to the board its medical staff resignations. Reports concerning physician privileges and resignations shall be made in accordance with G.S. 90-14.13. Any person making a report required by this section shall be immune from any resulting criminal prosecution or civil liability unless the person knew the report was false or acted in reckless disregard of whether the report was false."

SECTION 10.(a) The subcommittee of the North Carolina Medical Board and the subcommittee of the Board of Nursing, directed to work jointly to develop rules to govern the performance of medical acts by registered nurses pursuant to G.S. 90-6(b), shall examine adding the provisions of G.S. 90-14(a) to their joint rules that set forth grounds for action against a registered nurse's approval to perform medical acts.

SECTION 10.(b) The subcommittee of the North Carolina Medical Board and the subcommittee of the North Carolina Board of Pharmacy, directed to work jointly to develop rules to govern the performance of medical acts by clinical pharmacist practitioners pursuant to G.S. 90-6(c), shall examine adding the provisions of G.S. 90-14(a) to the joint rules that set forth grounds for action against a clinical pharmacist practitioner's approval to perform medical acts.

SECTION 10.(c) The North Carolina Medical Board, the Board of Nursing, and the North Carolina Board of Pharmacy shall report to the Chairs of the House Committee on Health, the Senate Committee on Health Care, the House Select Committee on Health Care, and the Subcommittee on Patient Safety, Quality and Accountability of the House Select Committee on Health Care on the adoption of the provisions of G.S. 90-14(a) as part of the joint rules governing the practice of medical acts for nurse practitioners and clinical pharmacist practitioners. The boards shall file their reports no later than September 1, 2006.

SECTION 10.(d) The North Carolina Medical Board shall examine the provisions of G.S. 90-14.13 and may develop policies or guidance governing the reporting requirements of that section. The Medical Board may recommend additional legislation, if necessary, to implement these policies prior to the convening of the 2007 General Assembly.

SECTION 11. Sections 4 through 9 of this act become effective October 1, 2006. The remainder of this act is effective when it becomes law. Section 4 applies to acts or omissions that occur on or after the effective date. Section 5 applies to hearings held on or after the effective date. Section 6 applies to awards entered or settlements entered into on or after the effective date.

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John S. Noseh	Greensboro Orthopaedics 1401 Benjamin Pkwy Greensboro 27408
Peter S. Donaldson	Digestive Health Specialists, P.A. 2025 Frontis Plaza, Winston-Salem, NC 27103
Kristen Shepherd	NC Medical Society
Susan Childs	Evolution Healthcare Consulting 1005 Walkertfield Rd Rougemont NC27572
Thom Mansfield	NC Medical Board
[illegible]	NCOTA & NCOS
Jim Edgerton	AHEC

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DR. JEAN McCALL, PT	NC PHYSICAL THERAPY / MILLBROOK RD RALEIGH, NC
DAN DORE, PT	NC. Physical Therapy Assoc.
SUSAN WOLF	Wendover OB/GYN G'boro
Melissa Strickland	Guilford Orthopaedic & Sports Medicine 650
Mary Ellen Workman	Central Carolina Surgery. PA
Fran Sumbert	Eagle Phys + Assoc. Greensboro
Chris Valauri	Valauri Group / NC Beer & Wine
Adam S. Keith	NCGA Intern - Sen. Doug Berger.
Gordy McCollin	NC. Conservation Network.
John Barkley	DOJ For HHS, DENR
David McLeod	NCDA+CS

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris Stoat	Christian Science Committee on Publication
CP Medlin	NCATC
P. Pulley	NCATC
Marcus Downs	NC State Health Plan
Laura Sanborn	NC MGM
Kristin Kelly	gov. office
Kathryn Pomeroy	Gov's office
Charles Baglione	DR. DHY
Patti Ross, RN	Nurse of the Day
Roz Sawitt	NC Child Care Coalition
Cammy R Benton	North Carolina Medical Society
Bill Wilson	AARP

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Leonard	WESR
Barbara Conslee	BSCGR
DAVID BARNES	Poyner + Spruill
Peggy Mangum	
HUGH TILSON	NCHA
STEVE KING	NCMS
Lee Hodges	KCLL
Tracy Kimbrell	Parker Poe.
BRUCE THOMPSON	PARKER POE
JOANN Skeens	Office of Skeens & Read, PCGNP

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trent Proctor	NCAA
Fred Baars	Baars & Assoc.
Evelyn Hawthorne	OHCR
[illegible]	[illegible]
Lou Stilson	NCAHTCF
Henry Jones	Attorney - Raleigh
Amy Jo Horne	NCNS
[illegible]	[illegible]
Jeff Wolfe	Daily Bulletin
Richard C Hatch	AARP
Dennis D. Hatch	AARP

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susie Cunningham	NCMS
Robert Reid, Jr MD	NCMS/NCAFP
Michael Cardwell	MGMA
Pam Saunders	MGMA
Molly Ryan	NCSBA
Katherine Joyce	NCASA
Allison Cagle	NCMS
Edward T. Plyler, MD	physician
Christopher Snyder, III, MD	NCMS / NCAFP
Jim Jones, MD	Family Physician
Michelle Jones, MD	NCAFP

VISITOR REGISTRATION SHEET

Health and Human Resources — **June 28, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Linda Alexander	NC MGM
Christina Young	NC Medical Group MGRS
Jami Fitzgerald	NC Family Policy Council
Polly Williams	Friends of Residents / NC Justice Center
Donald L. Copeland, MD	NC Family Physicians
BRIAN SHANK	ASTRAZENECA
John Bowdich	Astra Zeneca
MOTT BLAIR MD	Family Physician
Gregory K. Briggs, MPA	NCAFP
Christine Young	Wake Med
CARSON ROUNDS / MD	NCAFP

AGENDA

SENATE HEALTH CARE COMMITTEE
June 29, 2006, at 1:00 P.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bills to be Considered

- **HB 2059 LTC Fines Posted on Internet** — **Rep. Weiss**

  Rep. Bordsen
  Rep. Insko

IV Other Business

V. Adjournment

`SENATE HEALTH CARE COMMITTEE
Thursday June 29, 2006
1:00 P.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 1:00 P.M. on Thursday, June 29, 2006, in Room 544 of the Legislative Office Building, with fourteen members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell recognized Representative Jennifer Weiss to bring HB 2059, *LTC Fines Posted on Internet* before the committee. After much discussion, questions, and concerns voiced by the committee members, it was decided not to take a vote on this bill at this time.

The meeting adjourned at 1:30 P.M.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Lorraine R. Blake, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 2

HOUSE BILL 2059*
Committee Substitute Favorable 6/7/06

Short Title: LTC Fines Posted on Internet. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, TO POST THE FINES AND PENALTIES ASSESSED TO LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Facility Services, shall establish and maintain a list of fines and penalties imposed on nursing homes licensed pursuant to Article 6 of Chapter 131E of the General Statutes, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes, along with a record of fines or payments made pursuant to settlement agreements and the dates such payments were made. The list shall be accessible on the Internet and implemented not later than October 15, 2006. The Department shall report on the implementation of the list to the North Carolina Study Commission on Aging not later than November 1, 2006.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 2059*

Committee Substitute Favorable 6/7/06

PROPOSED SENATE COMMITTEE SUBSTITUTE H2059-CSSQ-66 [v.2]

6/22/2006 4:23:46 PM

Short Title: LTC Fines Posted on Internet. (Public)

Sponsors:

Referred to:

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, TO POST THE VIOLATIONS, FINES AND PENALTIES ASSESSED TO LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Facility Services, shall establish and maintain a list of violations resulting in negative licensure actions, fines and penalties imposed on nursing homes licensed pursuant to Article 6 of Chapter 131E of the General Statutes, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes. The list shall also contain a record of the dates of the violations which resulted in negative licensure actions, fines and penalties; the dates negative actions, fines and penalties were imposed; and a record of the date and amount of fines paid or payments made including payments made pursuant to settlement agreements. The list shall include violations, fines and penalties assessed after October 1, 2006, and shall be accessible on the Internet and implemented not later than October 15, 2006. The Department shall report on the implementation of the list to the North Carolina Study Commission on Aging not later than November 1, 2006.

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

HOUSE BILL 2059:
LTC Fines Posted on Internet

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 21, 2006
Introduced by:	Reps. Earle, Weiss, Bordsen	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: ***House Bill 2059 directs the Department of Health and Human Services, Division of Facility Services, to maintain a list on the Internet of violations, fines, penalties, and payments made pursuant to settlement agreements assessed to nursing homes and adult care homes. The bill is a recommendation from the Study Commission on Aging.***

The Senate Proposed Committee Substitute limits the list of violations to those resulting negative licensure action. The Senate PCS also requires the list to include violations, fines and penalties assessed on and after October 1, 2006.

BILL ANALYSIS:

The Senate PCS to House Bill 2059 implements a recommendation of the Study Commission on Aging, directing the Department of Health and Human Services, Division of Facility Services, to create and maintain a list of the violations resulting in negative licensure action, fines and penalties that are assessed to nursing homes licensed under Article 6 of Chapter 131E and that are assessed to adult care homes licensed under Article 1 of Chapter 131D. The bill also requires the Department to list the date those actions were imposed, a record of the date and the amount of the fines or payments made pursuant to settlement agreements and the dates the payments were made.

The bill requires the list be available on the Internet by October 15, 2006 and to include violations, fines and penalties assessed on and after October 1, 2006. The Department is required to report on the implementation of the list to the Study Commission on Aging by November 1, 2006.

The bill becomes effective when it becomes law.

BACKGROUND:

The Study Commission on Aging heard a presentation on March 15, 2006 from the Division of Facility Services that the fines and penalties assessed to long-term care facilities are not currently posted in a location that is accessible to the public.

Currently consumers evaluating nursing homes can access information on the internet regarding nursing homes. The "Nursing Home Compare" on the Medicare website contains information on regulatory requirements that nursing homes failed to meet, but the site does not provide an entire inspection report. According to the website, "a complete inspection report and the nursing home's corresponding plan of correction to address the deficiencies found during the inspection are available from the State survey agency or from the nursing home itself. In addition, each nursing home that provides Medicare or Medicaid services is required to make the results of its last full inspection available onsite for public review." The Nursing Home Compare can be found at: http://www.medicare.gov/NHCompare/home.asp

Information for adult care homes is not readily available. The Commission believes that timely posting the fines and penalties would be valuable resource to consumers.

Theresa Matula contributed to this summary.

H2059e2-SMSQ

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 29, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Bethel	AARP - NC
Cathy McConnell	AARP NC
Bill Wilson	AARP NC
Dick Hatch	AARP-NC
John Saddler	Friends of Residents in LTC
Abby N. Emanuelson	NMSS
Marcus Downs	NC State Health Plan
Patricia A Yancey	FOR LTC
Jenny Cooper	NCHCA
Evelyn Hawthorne	LTHGR
Jeff Wolfe	Daily Bulletin

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 29, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Jo Horne	NCMS
Lyn B. Wilson	NCALTCF
Stacy Flannery	NCHCFA
John McMillan	MFHS
Barbara Canada	BCBSNC
Cam Cowe	BPMHL
Bob Fitzgerald	DHHS/DFS
Marcia Plescia	DHHS/DPH
Lynn	HSC
Roz Savitt	NCCCC
Amy Schilder	HANC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 29, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	RANE - NCWLA
[signature]	[signature]
[signature]	WCSR
Alex Sewell	WCSR
[signature]	WCSR
[signature]	CWA
Jim Blackburn	NC ~~Attorney~~ Assoc of County Commissions
Jeff VAN DYKE	BELLSOUTH
MARK CREECH	CAL
ANTHONY ALLEN	NCAE

Senate Health Care Committee
Friday, July 7, 2006, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 448	**Complaints Against School Board Members.**	**Representative Yongue** **Representative Johnson** **Representative Glazier**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Friday, July 07, 2006

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) **448** Complaints Against School Board Members.

Draft Number:	PCS 60854
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Friday, July 7, 2006
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Friday, June 7, 2006, in Room 544 of the Legislative Office Building, with nine members present. Senator Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Bingham stated there was only one bill on the calendar, HB 448, ***Complaints Against School Board Members.*** Senator Purcell moved to adopt the PCS for discussion, which changes the title of the bill to ***Community Colleges Exempt from Smoking Laws.*** The motion passed unanimously. Representative Rick Glazier and Representative Susan Fisher were present to explain the bill. Representative Glazier stated that the bill was Representative Fisher's idea and genesis from her office. Basically the bill will add to the list of buildings or areas that can be exempt and be created as non-smoking areas. The decision will be totally left to each individual college's trustees to determine whether they will be exempt and be created as non-smoking. Representative Glazier pointed out this is not mandatory and there is no opposition. Representative Fisher was recognized and she wanted to express her thanks to Representative Glazier for finding a vehicle for this legislation. She stated the legislation started from a request from her local Community College in Asheville. She also expressed her thanks to the committee for having a special meeting in order to get it taken care of before the end of the session. Senator Dannelly moved to give the PCS a favorable report, unfavorable to the original bill.

The meeting adjourned at 11:15 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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 448

Committee Substitute Favorable 5/12/05
Third Edition Engrossed 5/31/05

Short Title: Complaints Against School Board Members. (Public)

Sponsors:

Referred to:

March 2, 2005

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A FAIR AND ORDERLY PROCESS FOR THE DISPOSITION OF COMPLAINTS AGAINST LOCAL SCHOOL BOARD MEMBERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-39 reads as rewritten:

"**§ 115C-39. Removal of board members; suspension of duties by State Board.**

~~(a) In case the State Board of Education has sufficient evidence that any member of a local board of education is not capable of discharging, or is not discharging, the duties of his office as required by law, or is guilty of immoral or disreputable conduct, the State Board of Education shall notify the chairman of such board of education, unless such chairman is the offending member, in which case all other members of such board shall be notified. Upon receipt of such notice there shall be a meeting of said board of education for the purpose of investigating the charges, and if the charges are found to be true, such board shall declare the office vacant: Provided, that the offending member shall be given proper notice of the hearing and that record of the findings of the other members shall be recorded in the minutes of such board of education.~~

(a) Policy. – The General Assembly finds that service on a local board of education is a public trust that requires each board member to demonstrate honesty, integrity, and ethical behavior and that the great majority of board members have demonstrated and continue to demonstrate these qualities. When board members do not display these qualities, public schools are hindered in their efforts to instill in students the moral and ethical values promoted under G.S. 115C-81(h).

It is the policy of the State of North Carolina that members of local boards of education must exhibit honesty, integrity, and ethical behavior in their personal lives as well as in the performance of their duties as board members.

(a1) Complaint Against a Board Member. – Any person may submit evidence to the State Board of Education that a member of a local board of education:

(1) Is not capable of discharging, or is willfully failing to discharge, the duties of the office as required by law, or

(2) Is guilty of illegal, immoral, or disreputable conduct that substantially impairs the member's ability to discharge the duties of the office. The entry of a plea of guilty or nolo contendere to, or the conviction of, any felony or any Class A1 misdemeanor or Class 1 misdemeanor shall be presumptive evidence of illegal, immoral, or disreputable conduct.

(a2) Review of Evidence. – Upon receipt of such evidence, the chair of the State Board of Education shall, in his or her discretion, either (i) review the evidence to determine whether, if taken as true, it would be sufficient to establish either of the grounds set out in subsection (a1) of this section or (ii) refer the evidence to the entire Board to make the determination. The chair or the Board may consider evidence of illegal conduct that occurred prior to the person becoming a member of the local board as evidence of illegal, immoral, or disreputable conduct that substantially impairs the member's ability to discharge the duties of the office. The determination shall be based solely upon the evidence that has been submitted pursuant to subsection (a1) of this section.

If the chair or the Board find that, if taken as true, the evidence would be sufficient to establish either of the grounds set out in subsection (a1) of this section, the chair or the Board shall notify the member against whom the complaint has been made and all other members of the local board.

(a3) Investigation and Determination by the Local Board. – Upon receipt of notice under subsection (a2) of this section, the local board of education shall conduct a hearing to determine the truthfulness of the charges and whether the conduct substantially impairs the member's ability to perform the duties of the office. The local board shall provide the member with proper notice of the hearing and the opportunity to be represented by counsel, present evidence, and examine and cross-examine witnesses. If the local board finds the charges to be true and that the conduct substantially impairs the member's ability to perform the duties of the office, it shall declare the office vacant. The local board shall record its findings in the official minutes of the board.

(b) Suspension of Powers and Duties. – In the event the State Board of Education has appointed an interim superintendent under G.S. 115C-105.39 and the State Board determines that the local board of education has failed to cooperate with the interim superintendent, the State Board shall have the authority to suspend any of the powers and duties of the local board and to act on its behalf under G.S. 115C-105.39."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 448

Committee Substitute Favorable 5/12/05

Third Edition Engrossed 5/31/05

PROPOSED SENATE COMMITTEE SUBSTITUTE H448-CSSQ-73 [v.1]

7/5/2006 1:16:22 PM

Short Title: Community Colleges Exempt from Smoking Laws. (Public)

Sponsors:

Referred to:

March 2, 2005

A BILL TO BE ENTITLED

AN ACT TO EXEMPT COMMUNITY COLLEGES FROM THE LAW GOVERNING SMOKING RESTRICTIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-599 reads as rewritten:

"**§ 143-599. Exemptions.**

All of the following facilities shall be exempt from the provisions of this Article:

(1) Any primary or secondary school or child care center, except for a teacher's lounge.

(2) An enclosed elevator.

(3) Public school bus.

(4) Hospital, nursing home, rest home, and State facility operated under the authority of G.S. 122C-181.

(5) Local health department and local department of social services and the building and grounds where the local health department or local department of social services, as applicable, is located. For the purposes of this subdivision, "grounds" means the area located within 50 linear feet of a local health department or a local department of social services.

(6) Any nonprofit organization or corporation whose primary purpose is to discourage the use of tobacco products by the general public.

(7) Tobacco manufacturing, processing, and administrative facilities.

(8) Indoor arenas with a seating capacity greater than 23,000.

(9) State correctional facilities operated by the Department of Correction.

(10) Community colleges."

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

HOUSE BILL 448:
Community College Exempt from Smoking Laws

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 5, 2006
Introduced by:	Reps. Glazier, Yongue, Johnson	**Summary by:**	Shawn Parker
Version:	PCS to Third Edition H448-CSSQ-73		Legislative Analyst

SUMMARY: The Senate Proposed Committee Substitute would exempt community colleges from current laws governing smoking restrictions. This act would allow community colleges to ban smoking from community college premises.

CURRENT LAW: Article 64 of the General Statutes addresses the needs and concerns of both smokers and nonsmokers in public places by providing for designated smoking and nonsmoking areas[1]. A list of buildings owned, leased or occupied by State government which may be designated as nonsmoking areas is set forth, including: museums, libraries, and UNC health services facilities. Nonsmoking areas must be visibly posted as such, and requirements for separate ventilation systems and physical barriers between nonsmoking and adjacent smoking areas are provided for in the statute[2].

Violation by continuing to smoke in a nonsmoking area after having been given notice to stop smoking is an infraction punishable by a fine of not more than $25.00[3]. Local ordinances, laws or rules passed on or after October 15, 1993 regulating smoking may not contain restrictions exceeding those of Article 64 and may only address smoking in specifically identified types of facilities[4].

An itemized list of facilities specifically exempted from regulation by the provisions of Article 64 is set forth in G.S. 143-599, including the following: any primary or secondary school, child care center (teacher's lounge excepted), enclosed elevators, public school buses, hospitals, nursing homes, rest homes, local health departments, organizations intended to discourage tobacco use, and tobacco manufacturing, processing and administrative facilities.

BILL ANALYSIS: The Senate PCS to House Bill 448 would expand the coverage of the exemption in G.S. 143-599(5) to include community colleges, thereby allowing community college campuses to be designated as nonsmoking areas.

EFFECTIVE DATE: This act is effective when it becomes law.

Ben Popkin contributed to this summary.

H0448e3-SMSQ-CSSQ-73

[1] G.S. 143-595.
[2] G.S. 143-597(b) & (c).
[3] G.S. 143-598.
[4] G.S. 143-601(b).

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 448

Committee Substitute Favorable 5/12/05
Third Edition Engrossed 5/31/05
PROPOSED SENATE COMMITTEE SUBSTITUTE H448-PCS60854-SQ-73

Short Title: Community Colleges Exempt from Smoking Laws. (Public)

Sponsors:

Referred to:

March 2, 2005

A BILL TO BE ENTITLED

AN ACT TO EXEMPT COMMUNITY COLLEGES FROM THE LAW GOVERNING SMOKING RESTRICTIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-599 reads as rewritten:

"**§ 143-599. Exemptions.**

All of the following facilities shall be exempt from the provisions of this Article:

(1) Any primary or secondary school or child care center, except for a teacher's lounge.
(2) An enclosed elevator.
(3) Public school bus.
(4) Hospital, nursing home, rest home, and State facility operated under the authority of G.S. 122C-181.
(5) Local health department and local department of social services and the building and grounds where the local health department or local department of social services, as applicable, is located. For the purposes of this subdivision, "grounds" means the area located within 50 linear feet of a local health department or a local department of social services.
(6) Any nonprofit organization or corporation whose primary purpose is to discourage the use of tobacco products by the general public.
(7) Tobacco manufacturing, processing, and administrative facilities.
(8) Indoor arenas with a seating capacity greater than 23,000.
(9) State correctional facilities operated by the Department of Correction.
(10) Community colleges."

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

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 7, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lauren Rogers	NC Family Policy Council
Jim Blackburn	NC Association of County Commissioners
Kristin Kelly	gov. office

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 7, 2006**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Caroline Howe	Lt. Gov's Office
Mike Arnold	" "
Harry Wilson	SBE
Steve Keene	NCMS
Emily Lynch	NCMS
Amy Jo Horne	NCMS
[illegible]	[illegible]
[illegible]	[illegible]
Patrick Byfield	Alley Associates, Inc.
Les Hodge	KCLH
Jimmi Fitzgerald	NCFPC

AGENDA

SENATE HEALTH CARE COMMITTEE
July 12, 2006, at 11:00 A.M.
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bill to be Considered

- **HB 2576 Special Assistance In-Home Assign.** **Rep. Clary**
  Rep. Insko
  Rep. Earle
  Rep. Martin

IV Other Business

V. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, July 12, 2006

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

FAVORABLE

H.B. **2576** Special Assistance In-Home Assign.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

`SENATE HEALTH CARE COMMITTEE
Wednesday, July 12, 2006
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 12, 2006, in Room 544 of the Legislative Office Building, with twelve members present. Senator William R. Purcell presided. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms.

Senator Purcell asked Representative Clary to present H.B. 2576, *Special Assistance In-Home Assign.* She said that the bill would raise the number of slots available to persons who choose to stay home, with assistance, rather than go to an adult care facility. She pointed out that 28 North Carolina counties are not participating in this program, and raising the number of slots would enable them to do so. Senator Dannelly asked the difference in cost to the state between those choosing to stay home and those in a nursing facility. Rep. Clary referred the question to Jim Edgerton of the Association for Home and Hospice Care, who said that the difference is 75 percent of the cost of an adult care home. Senator Purcell recognized Suzanne Merrill of the Division of Aging, who said that the average payment for at-home care is $339 per month, as against $460 per month for facility care. Senator Kinnaird asked about the kind of services provided in-home, and Rep. Clary responded that an assessment is made to determine what is needed. Senator Dorsett asked what criteria were used to determine those eligible for the choice to stay home. Rep. Clary said that it was based on the counties that asked to participate in the program. Senator Forrester asked if the in-home programs are monitored and if they are subject to fines. She referred the question to Mr. Edgerton, who said that all home health agencies are licensed by the Division of Facility Services and that all home health care agencies are surveyed every three years; and are not fined. Senator Bingham asked if a fiscal note is needed. Rep. Clary pointed out that monies needed would come from existing accounts, and are already appropriated. Senator Dorsett asked if those choosing the in-home program would have to deplete resources, as do those going into an adult care home, and the response was that they would have to meet the same income requirements but they would be able to keep resources such as homes. Senator Kinnaird asked if this program also applies to mental health patients, and the answer was that some mental health patients are taking advantage of this program. Ms. Lou Wilson, Mr. Edgerton, and Ms. Mary Bethel of AARP were recognized and made additional comments. Senator Dannelly moved for a favorable report, and the bill passed.

The meeting adjourned at 11:30 A.M.

William K. 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 2005

H 1

HOUSE BILL 2576

Short Title:	Special Assistance In-Home Assign.	(Public)
Sponsors:	Representatives Clary, Insko, Earle, Martin (Primary Sponsors); B. Allen, Bordsen, Faison, Farmer-Butterfield, Fisher, Glazier, LaRoque, Ross, Sherrill, Tolson, Tucker, Weiss, and Womble.	
Referred to:	Health.	

May 25, 2006

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE NUMBER OF ASSIGNMENTS TO THE SPECIAL ASSISTANCE IN-HOME PROGRAM OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Funds appropriated to the Department of Health and Human Services for the 2006-2007 fiscal year may be used to increase the maximum number of assignments to the special assistance in-home program to 1,500 persons.

SECTION 2. This act becomes effective July 1, 2006.

HOUSE BILL 2576:
Special Assistance In-Home Assign

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 11, 2006
Introduced by:	Reps. Clary, Insko, Earle, Martin	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: House Bill 2576 would allow for funds appropriated to the Department of Health and Human Services for the 2006-2007 fiscal year to be used to increase the maximum number of assignments to the Special Assistance In-Home Program to 1,500 persons.

The Special Assistance In-Home Program, formerly known as the SA Demonstration Project, operates as an alternative to Adult Care Home (ACH) for individuals who can safely live at home with additional support services.

CURRENT LAW: Session Law 2005-276 authorized continuation and expansion of the Special Assistance In-Home Program from 800 to 1000 eligible applicants nationwide. Participation is voluntary on the part of the county departments of social services.

BILL ANALYSIS: House Bill 2576 would allow the Department of Health and Human Services to use funds appropriated for the 2006-2007 fiscal year to increase the maximum number of assignments to the special assistance in-home program to 1,500 persons.

EFFECTIVE DATE: This act becomes effective July 1, 2006.

BACKGROUND: The Special Assistance In-Home Program, formerly known as the SA Demonstration Project, was created in Session Law 1999-237 by providing State/County Special Assistance funds to be used for payments for up to 400 eligible individuals in in-home living arrangements.

The program was expanded in Session Law 2003-284 to include 800 eligible individuals nationwide.

Session Law 2005-276 increased the maximum number of individuals to 1000 and payments were raised from 50% to 75% of the monthly payment the individual would have received if she/he were a resident of an adult care home and qualified for Special Assistance.

Morgan Jones, Research Division temporary research assistant, substantially contributed to this summary.

H2576e1-SMSQ

Month	SA/In-Home, Number of Monthly Payments	Increase	% Growth	SA/ACH Number of Monthly Payments	Increase	% Growth
Jul-04	497			24,536		
Aug-04	531	34	6.84%	24,666	130	0.53%
Sep-04	569	38	7.16%	24,658	-8	-0.03%
Oct-04	576	7	1.23%	24,811	153	0.62%
Nov-04	595	19	3.30%	24,718	-93	-0.37%
Dec-04	613	18	3.03%	24,689	-29	-0.12%
Jan-05	631	18	2.94%	25,700	1011	4.09%
Feb-05	646	15	2.38%	24,952	-748	-2.91%
Mar-05	671	25	3.87%	24,903	-49	-0.20%
Apr-05	694	23	3.43%	24,801	-102	-0.41%
May-05	703	9	1.30%	24,791	-10	-0.04%
Jun-05	702	-1	-0.14%	24,844	53	0.21%

Total...205 clients- 30% 308 residents-1%

SA-In-Home increased 30%--SFY2004-05
SA in facilities increased 1%--SFY2004-05

In 1998 DHHS projected the potential eligibles for this program to exceed 32,000 persons.

Historically, DHHS has had no uniform screening program to ensure medical eligibility requirements are uniformly and accurately applied across CA/DA and nursing homes. Therefore according to The CAP/DA Report presented to The Aging Study Commission, April 4, 2006 "approximately 11% or 1279 CAP/DA recipients may not meet nursing home level of care".

The average annual cost per CAP/DA client is $31,077.* Does this mean that 1279 consumers used more than $39,000,000 in one year of public funds for which they did not qualify?

There is currently NO screening program in place to assure uniformity across the adult care home and SA-In-Home populations.

Does this put the state at risk of using public funds, of which 50% are county funds, for persons who may not qualify in a program that is increasing 30 annually?

*CAP/DA REPORT, March 1, 2004, by NC DHHS

Lorraine Blake (Sen. Purcell)

From: Shawn Parker (Research)
Sent: Wednesday, July 12, 2006 10:33 AM
To: Sen. William Purcell; Lorraine Blake (Sen. Purcell); Becky Hedspeth (Sen. Purcell)
Cc: Theresa Matula (Research)
Subject: Information on Special Assistance in Home Program

Special Assistance In-Home Program provides an alternative to placement in an Adult Care Home for individuals who could live at home safely with additional support services.

Participation is voluntary on the part of the county departments of social services. The program began with participation from 22 counties (an RFP was distributed because the initial slots were capped at 400, or just 4 per county which would not have been economically feasible), the program was expanded to 800 slots in 2003 allowing 61 counties to participate.

Individuals who wish to receive an SA In-Home payment must have income below the federal poverty level; be eligible for Medicaid; be eligible for SA; have an FL-2 indicating a need for Adult Care Home level of care; and have an assessment and service plan that indicates the individual can live safely at home with services.

The Division of Aging tracks slots and slot usage and is in charge of rule making and procedures.

If there are any questions beyond the policy piece of allowing the Division to authorize more slots, someone from the Division would be best to answer. I think Suzanne Merrill is the person who oversees the SA-in home program.

Shawn

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 12, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	[signature]
Julie Lowery CLRA	198 Norwood Rd Chapel Hill 27516 /NCANA
Joanne Stevens	nursing
Cally Wiggins	Gov.'s office
ANTHONY ALLEN	NCAEC
JIM BAUGBURN	NCAOC
Lauren Rogers	NCFPU
[signature]	Bone & Assoc. — LTC
Lou Wilson	Long Term Care
BRIAN SHANK	ASTRAZENECA
John Bowdish	AstraZeneca

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 12, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Barbara Canales	BCBSNC
Frank Gray	NCANA
Jim Blackburn	County Commissioners Association
Hugh Tilson	NCHA
Dana Simpson	Smith Anderson
STEVE KEENE	NCPHP
Warren Pendergast MD	NCPHP / Doctor of the Day
JAN B. SANTOSTEFANO	NURSE OF THE DAY SAS INSTITUTE
Cathy McConnell	AARP - NC
Mary Bethea	AARP - NC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 12, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Holly Bryan	NCATL
Chris Medlin	NCATL
Sidney E. Dunston	Franklin County Commissioner
A J Home	NC Medical Society

Senate Health Care Committee
Tuesday, July 18, 2006, 12:00 Noon
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 2037	**Medicaid Reimburse. for Ocular Prosthetists.**	**Representative Stiller**
HB 2699	**Vision Care Program Changes.**	**Representative Yongue** **Representative Coleman** **Representative Haire** **Representative Wright**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Tuesday, July 18, 2006

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) **2699** Vision Care Program Changes.

Draft Number:	10650
Sequential Referral:	None
Recommended Referral:	None.
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Tuesday, July 18, 2006

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

FAVORABLE

H.B.(CS #1) **2037** Medicaid Reimburse. for Ocular Prosthetists.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

Senate Health Care Committee
Tuesday July 18, 2006
12:00 Noon
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 12:00 noon on Tuesday July 18, 2006, in Room 544 of the Legislative Office Building, with thirteen members present. Senator Stan Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at-arms. Also recognized and welcomed were Sarah Holloway and Simone Porter, Pediatric Residents.

Senator Bingham recognized Representative Stiller to present HB 2037, ***Medicaid Reimbursements for Ocular Prosthetists***. Representative Stiller stated that this bill would clear up an oversight that happened in last year's budget. The bill will expand Medicaid reimbursement eligibility to include providers of ocular prosthetics who are certified, licensed or accredited in accordance with the requirements established by DHHS. The bill came from the Joint Legislative Administrative Procedure Oversight Committee. Senator Dorsett asked if this was different than the senate bill that was passed, which Senator Webster brought forward. Representative Stiller stated there is no difference, that Senator Webster was working on this and then out of the Administrative Procedure they divided the bills up and brought this from the House side. Senator Dorsett asked what happened to the one they passed on the Senate Side. Representative Stiller did not know the status of the Senate Bill and stated this was working in conjunction with Senator Webster. Shawn Parker, Research, stated this bill is modification to this year's budget and the previous bill was for last year's budget. Senator Dorsett moved for a favorable report and the bill passed.

Representative Coleman was recognized to present HB 2699, ***Vision Care Program Changes***. Representative Coleman stated that this bill got a lot of negative publicity last year the way it was introduced in the budget. Representative Coleman feels the bill offers some absolutely wonderful benefits to our state's children and she wants to salvage the bill and take the politics out of it. This is a compromise bill with all the partners who had input including the Medical Society, Ophthalmologist, Pediatricians, Family Physicians, Optometrist, School Board Associations, and the Prevention for Blindness. The bill passed the House unanimously. It will be the children who will benefit from the bill and staff will provide the analysis. Shawn Parker, Research, explained it modifies the vision care program that was established in Session Law 2005-276. Beginning in the 2007-2008 school year, Section (1) requires the Governor's Commission on Early Childhood Vision Care to adopt standards for vision care screenings. This requirement applies to children entering kindergarten and to students who enter first grade without having been enrolled in kindergarten. Licensed physician, optometrist, physician assistant, nurse practitioner, registered nurse, orthoptist shall conduct the screening, or a vision screener certified by Prevent Blindness North Carolina Board. The parent or guardian shall have 180 days from the start of the school year to present a standard certificate verifying the screening has been performed within the past twelve months. No child will be excluded from attending kindergarten for failure to

obtain a comprehensive eye exam. Section 2(a) changes the Membership of the Commission on Early Childhood Vision Care from six to ten. The appointments made by Speaker of the House and the President Pro-Tempore of the Senate remain the same. The Governor appoints four optometrists, two ophthalmologists, (of which one must be currently serving member of the Prevent Blindness NC Board), one pediatrician with a family practice or a family physician who provides services to children, and one school nurse who is certified by the Prevent Blindness NC Board. Section 2(b) requires the DHHS, Division of Public Health to compile data on children receiving comprehensive eye exams and report the results annually to the Governor's Commission on Early Childhood Vision Care, the Fiscal Research Division, and the House and Senate Appropriations Subcommittee on Health and Human Services. Section 3 authorizes the Division of Public Health, from funds appropriated for the 2006-2007 fiscal year, to reimburse providers for comprehensive exams and corrective lenses provided to eligible families. The section directs the Division to work with the Commission to establish procedure for reimbursements. Section 4 allows the Department to use up to five percent of funds appropriated to the vision care program for operations and expenses, this being $500,000 this budget cycle. Section 5 allows the Commission to adopt rules to implement the act. Section 6 deems children that have received vision screenings prior to the availability of forms, to have obtained the required screening, meaning they will be grandfathered-in. Senator Purcell was recognized to explain the first amendment which changed words on page 1, line 13 by deleting the word "passed" and substituting the word "obtained", and on page 1, line 26, by deleting the word "that" and substituting the word "who". Senator Dannelly moved for a favorable report on the amendment, which passed. Senator Purcell was recognized to explain his second amendment. Senator Purcell stated there were concerns expressed by DPI about the problem of having as many as a 100,000 new kindergarten students each year and 20,0000 could need these comprehensive exams. The amendment asked for a study to determine feasibility of compiling the data due to the concerns about the burden put on schools. Senator Coleman replied they are concerned with this and are afraid if the word "feasibility" is used it will kill the bill. Senator Coleman would like for the word to be "methodology" instead of "feasibility". Senator Purcell replied the "feasibility" gives more options to DPI on how they deal with the problem. Leanne E. Winner, North Carolina School Boards Association, stated as the bill is currently written the Department of Human and Health Services (DHHS) is required to start collecting the data on the children who receive the comprehensive eye exam to evaluate the program. There are major concerns of how DHHS will collect the data. There are no other options at the moment to collect the data except to turn to the schools to supply the reports back to the DHHS. Senator Dannelly asked what is the difference between "methodology" and "feasibility". Leanne Winner answered it does not matter if it says "methodology" or "feasibility" just so long as it is a study. Senator Dannelly moved for a favorable report on the amendment, including "methodology" instead of "feasibility", which passed. Senator Allran asked what is the difference between the standards of qualification for doing screening now and the new way of screening. Representative Coleman responded that now there are no standards in place. The bill will establish a standard. Senator Allran asked what if persons apply and there is no money. Rep. Coleman responded there are four methods for children to receive funding. Medicaid-eligible will still be eligible, then there is going to be a foundation that the optometrist are going to start that will have a minimum of $50,000, some parents

have insurance, and they are going to establish a fund with the $500,000. Senator Allran stated he thought it was money well spent. Senator Berger asked why they are changing their board. Rep. Coleman stated they felt like the school nurses should be included and Prevent Blindness wanted to be a part of this. Senator Berger wanted to know why they are increasing ophthalmologist. Senator Berger stated that earlier this year while looking to repeal the comprehensive eye exam, it was clear there were fundamental differences between the optometrist and the ophthalmologist as to what is necessary in terms of screening children, so why was there an increase. Rep. Coleman stated they added the slots to include Prevent Blindness. Senator Hartsell asked if any of these screening programs are available at local public health departments. Rep. Coleman stated she feels sure there are. Senator Purcell stated it appears a lot of kids are being missed but he does not see a lot of people being missed and he does not have a problem with having written standards. Senator Dannelly moved for a favorable report at the appropriate time. Senator Forrester asked about page l line 18 where it is asking Doctors to fill out another form. Rep. Coleman wants a form. Senator Forrester stated physicians now use charts and he stated it looks like this might change, making it so physicians cannot do the complete physical for the child and then the child will have to go to an optometrist or an ophthalmologist. Rep. Coleman said it should not cost anymore than what is being paid now. They have a check and balance group on the Commission because they do not want to impose another cost burden to this process. Senator Goodall asked if the screening was not passed and a comprehensive eye exam was required and that failure to get the exam would not preclude the child from attending school meaning there is no sanction if they do not get the examination. Jim Mills, with Fiscal Research, stated that any violation of public health laws are a class l misdemeanor and technically this could be violation of public health laws if the comprehensive exam was not obtained. Senator Nesbitt stated now that a screening will be required instead of the comprehensive eye examination, he wants to know if NC has in place a way to give everyone a screening free of charge. Rep. Coleman replied DHHS is doing that now. Every kindergarten student has to have a health assessment before starting school now and they are just putting the standards in place for the vision screenings. Senator Nesbitt also asked do they do vision screening at schools now. He needs to know if the people back home have to spend money on vision screening. Jennifer Talbert, Prevent Blindness North Carolina, stated they currently screen in all one hundred counties in public schools grades K-6, over 500,000 children, and it is free. Senator Dannelly had made the motion to roll the amendments into a new PCS, favorable to the PCS, unfavorable to the original bill, which passed.

The meeting adjourned at 1:00 P.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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 2037*

Committee Substitute Favorable 5/24/06

Third Edition Engrossed 7/11/06

Short Title: Medicaid Reimburse. for Ocular Prosthetists. (Public)

Sponsors:

Referred to:

May 17, 2006

A BILL TO BE ENTITLED

AN ACT TO CLARIFY MEDICAID REIMBURSEMENTS FOR OCULAR PROSTHETISTS.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.3(e)(24) of S.L. 2006-66 reads as rewritten:

"(24) Medically necessary prosthetics or orthotics. – In order to be eligible for reimbursement, providers must be licensed or certified by the occupational licensing board or the certification authority having authority over the provider's license or ~~certification.~~certification, or in the case of ocular prosthetists Board certified, licensed, or accredited in accordance with the requirements established by the Department. Medically necessary prosthetics and orthotics are subject to prior approval and utilization review."

SECTION 2. This act becomes effective July 1, 2006.

HOUSE BILL 2037:
Medicaid Reimburse. for Ocular Prosthetists

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 17, 2006
Introduced by:	Rep. Stiller	**Summary by:**	Shawn Parker
Version:	Third Edition		Legislative Analyst

SUMMARY: House Bill 2037 allows ocular prosthetists, who are Board certified, licensed, or accredited to be eligible for Medicaid reimbursement as recommended by the Joint Legislative Administrative Procedure Oversight Committee.

Effective July 1, 2006.

CURRENT LAW: Funds appropriated for services provided in accordance with Title XIX of the Social Security Act (Medicaid) are for both the categorically needy and the medically needy. Funds appropriated for these services are expended in accordance with the schedule of services and payment bases outlined in Session Law 2006-66, "Modify Appropriations Act of 2005".

To be eligible for reimbursement for medically necessary prosthetics and orthotics providers must be licensed or certified by the occupational licensing board or proper certification authority.

BILL ANALYSIS: The bill would expand Medicaid reimbursement eligibility to include providers of ocular prosthetics who are certified, licensed or accredited in accordance with the requirements established by the Department of Health and Human Services.

EFFECTIVE DATE: This act becomes effective July 1, 2006.

H2037e3-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

Legislative Fiscal Note

BILL NUMBER: House Bill 2037 (Second Edition)

SHORT TITLE: Medicaid Reimburse. for Ocular Prosthetists.

SPONSOR(S): Representative Stiller

FISCAL IMPACT

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

	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
REVENUES					
EXPENDITURES					
POSITIONS (cumulative):					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services: Division of Medical Assistance

EFFECTIVE DATE: July 1, 2006

BILL SUMMARY: The proposed legislation clarifies that Medicaid reimbursement for ocular prosthetists is available when the provider is board certified or accredited.

ASSUMPTIONS AND METHODOLOGY: The proposed legislation has no fiscal impact because the number of ocular prosthetics covered under the Medicaid Program will not be affected by the clarification that an ocular prosthetist be board certified or accredited.

SOURCES OF DATA: Department of Health and Human Services: Division of Medical Assistance

TECHNICAL CONSIDERATIONS: The proposed legislation amends Section 10.11(a) (23) of S.L. 2005-276. Section 10.11 of S.L. 2005-276 has been repealed and rewritten in Section 10.3(e)(24) of S.L. 2006-66..

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Carol Shaw

APPROVED BY: Lynn Muchmore

DATE: July 7, 2006

Official Fiscal Research Division Publication

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 2699

Committee Substitute Favorable 7/6/06

Third Edition Engrossed 7/6/06

Short Title: Vision Care Program Changes. (Public)

Sponsors:

Referred to:

May 25, 2006

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE VISION CARE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 130A-440.1 reads as rewritten:

"**§ 130A-440.1. ~~Comprehensive eye examination required.~~Early Childhood Vision Care.**

(a) Vision Screening Required for Children Entering Kindergarten. – Every child in this State entering kindergarten in the public schools, beginning with the 2007-2008 school year, shall obtain ~~a~~ vision screening in accordance with vision screening standards adopted by the Governor's Commission on Early Childhood Vision Care. Within 180 days of the start of the school year, the parent of the child shall present to the school principal or the principal's designee certification that the child has, within the past 12 months, passed vision screening conducted by a licensed physician, optometrist, physician assistant, nurse practitioner, registered nurse, orthoptist, or a vision screener certified by Prevent Blindness North Carolina, or a comprehensive eye examination performed by an ophthalmologist or optometrist. The health assessment transmittal form required pursuant to G.S. 130A-440 qualifies as certification that the child has obtained the required vision screening. All providers conducting vision screening shall provide each parent in writing the results of the vision screening on forms bearing the signature of the provider supplied to the provider by the Governor's Commission on Early Childhood Vision Care. The provider shall also orally communicate this information to the parent and shall take reasonable steps to insure that the parent understands the information communicated. In the instance where a child enters the first grade without having been enrolled in a kindergarten program requiring a vision screening, the requirements for vision screening under this subsection shall apply.

(a1) Comprehensive Eye Examination. – For children that receive and fail to pass a vision screening as required under subsections (a) of this section, a comprehensive eye examination is required. If a public school teacher, administrator, or other appropriate

school personnel has reason to believe that a child enrolled in kindergarten through third grade is having problems with vision, the school personnel may recommend to the child's parent that the child have a comprehensive eye examination. Notification to the parent shall also inform the parent that funds may be available from the Governor's Commission on Early Childhood Vision Care to pay providers for the examination, including corrective lenses.

~~(b) The comprehensive eye examination required under this section shall be conducted by an optometrist or ophthalmologist licensed to practice in this State. No child shall attend kindergarten unless a comprehensive eye examination transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the comprehensive eye examination required by this section, is presented to the school principal, except in cases where the child has moved to North Carolina within the 60 days immediately preceding school entry, in which case the child shall have 60 days from the date of school entry to submit the eye examination transmittal form required under this section. In the event a child is unable to obtain services after the 60-day period has elapsed, the principal shall report this information to the Commission so that the Commission may identify alternative ways to provide services to these children.~~The comprehensive eye examination shall be conducted by a duly licensed optometrist or ophthalmologist. The comprehensive eye examination conducted pursuant to this section shall consist of a complete and thorough examination of the eye and shall include: ~~human visual system that includes an evaluation, determination, and diagnosis of:~~

(1) Measurement of visual acuity;
(2) Ocular alignment and motility;
(3) Depth perception – stereopsis;
(4) Fusion;
(5) Slit lamp examination of the lid margins, conjunctivae, cornea, anterior chamber, iris and crystalline lens;
(6) Examination of the ocular adnexa, the anterior segment and pupils; and
(7) Cycloplegic refraction and dilated fundus examination.

~~(1) Visual acuity at distance and near;~~
~~(2) Alignment and ocular motility;~~
~~(3) Binocular fusion abnormalities, including tracking;~~
~~(4) Actual refractive errors, including verification by subject means;~~
~~(5) Any color vision disorder;~~
~~(6) Intraocular pressure as may be medically appropriate; and~~
~~(7) Ocular health, including internal and external assessment.~~

Health assessment vision screening under G.S. 130A-440 ~~does not meet the requirements of this section.~~is not a comprehensive eye examination for purposes of this section.

(c) The results of a comprehensive eye examination conducted under this section shall be included on the ~~The~~ comprehensive eye examination transmittal form developed by the Commission pursuant to G.S. 143B-216.75 and shall contain a summary of the comprehensive eye examination performed by the optometrist or

ophthalmologist. Any treatment recommendations by the optometrist or ophthalmologist, such as spectacles for schoolwork, shall appear in the summary and school health card. The provider shall present a signed transmittal form to the parent upon completion of the examination. The parent shall submit the transmittal form to the school in accordance with this section.

~~(d) This section shall not apply to children entering kindergarten in private church schools, schools of religious charter, or qualified nonpublic schools regulated by Article 39 of Chapter 115C of the General Statutes.~~

(e) G.S. 130A-441, 130A-442, and 130A-443, pertaining to health assessments, apply to comprehensive eye examinations required under this section.

(f) No child shall be excluded from attending school for a parent's failure to obtain a comprehensive eye examination required under this section. If a parent fails or refuses to obtain a comprehensive eye examination or to provide the certification of a comprehensive eye examination, the school shall send a written reminder to the parent of required eye examinations and shall include information about funds that may be available from the Governor's Commission on Early Childhood Vision Care.

(g) In adopting standards for vision screening under this section and as required under G.S. 130A-440, the Commission shall take into account the resources necessary to comply with the standards and, if standards will require additional resources, shall mitigate the impact on resources without compromising vision screening effectiveness.

(h) As used in the section, the term "parent" means the parent, guardian, or person standing in loco parentis."

SECTION 1.(b) G.S. 130A-440 reads as rewritten:

"(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. The health assessment may also include dental screening and developmental screening for cognition, language, and motor function.

SECTION 2.(a) G.S. 143B-216.75(b) reads as rewritten:

(a) There is established the Governor's Commission on Early Childhood Vision Care ("Commission"). The Commission shall be located in the Department of Health and Human Services for administrative and budgetary purposes only.

(b) The Commission shall consist of ~~six~~ ten members appointed as follows:

(1) ~~Two optometrists and two ophthalmologists,~~Four optometrists, two ophthalmologists, and one general pediatrician or a family physician who provides services to children, each of whom is licensed to practice in this State, and one school nurse who is certified by the Prevent Blindness North Carolina Board, appointed by the ~~Governor;~~Governor. Among the optometrists and ophthalmologists appointed by the Governor, one shall be a currently serving member of the Prevent Blindness North Carolina Board;

(2) One optometrist licensed to practice in this State appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives; and

(3) One ophthalmologist licensed to practice in this State appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.

The initial members appointed by the General Assembly shall each serve a one-year term. The initial members appointed by the Governor shall each serve a two-year term. Subsequent appointments shall be for three-year terms. Vacancies shall be filled by the original appointing authority.

(c) The Commission shall adopt rules to implement and administer the Governor's Vision Care Program established under this section. The rules shall address:

(1) Accepting and processing of applications by families for Program services.

(2) ~~Verification~~ Establishment and verification of applicant income eligibility.

(3) Reimbursement to providers for services provided to eligible participants.

(4) Informing providers and the general public about the Program.

(5) Other duties necessary to implement the purposes and requirements of this ~~section.~~section, including the development of a comprehensive eye examination transmittal form required under G.S. 130A-440.1.

The Commission shall develop alternative ways for providing services to children who qualify for the Program when funding for Program services has been exhausted.

The Commission shall prepare written information for providers conducting vision screening. The written information shall state, in effect: 'Vision screening is not a substitute for a comprehensive eye examination.' The Commission shall provide copies of this information to providers so that the provider may give a copy to the parent, guardian, or person standing in loco parentis."

SECTION 2.(b) The Governor's Commission on Early Childhood Vision Care shall work with the Department of Public Instruction to establish procedures for identifying and referring children who need vision screening or a comprehensive eye examination as required by G.S. 143B-216.75.

SECTION 2.(c) The Department of Health and Human Services, Division of Public Health, shall compile data on the number of children who received comprehensive eye examinations and the types of problems found and treatments provided, and shall report the results annually to the Governor's Commission on Early Childhood Vision Care, the Joint Legislative Health Care Oversight Committee, the House of Representatives Appropriations Subcommittee on the Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 2.(d) Section 10.59F.(b) of S.L. 2005-276, as amended by Section 20(b) of S.L. 2005-345, is repealed.

SECTION 3. Funds appropriated to the Department of Health and Human Services, Division of Public Health, for the 2006-2007 fiscal year shall be used to reimburse providers for comprehensive eye examination services, including corrective lenses, provided to eligible families. The Division of Public Health shall work with the

Governor's Commission on Early Childhood Vision Care to establish procedures for reimbursing providers. Eligibility requirements for reimbursement shall be as provided under G.S. 143B-216.75. The Governor's Commission on Early Childhood Vision Care shall establish procedures to inform parents about applying and qualifying for vision care services.

SECTION 4. The Department of Health and Human Services may use up to five percent (5%) of the funds appropriated for the Vision Care Program for the 2006-2007 fiscal year for Program operations and Commission expenses.

SECTION 5. The Governor's Commission on Early Childhood Vision Care may adopt temporary rules in accordance with G.S. 150B-21.1 to implement this act.

SECTION 6. Children that have received vision screenings prior to the availability of forms developed by the Governor's Commission on Early Childhood Vision Care in accordance with G.S. 130A-440.1 shall be deemed to have obtained the screening required under G.S. 130A-440.1, as amended by this act.

SECTION 7. This act is effective when it becomes law.

HOUSE BILL 2699:
Vision Care Program Changes

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 17, 2006
Introduced by:	Reps. Coleman, Wright, Yongue, Haire	**Summary by:**	Shawn Parker
Version:	Third Edition		Legislative Analyst

SUMMARY: ***House Bill 2699 modifies the Vision Care Program established by Session Law 2005-276.***

CURRENT LAW: Section 10.59F of Session Law 2005-276, the Appropriations Act, established the Governor's Vision Care Program and required for every child in the State entering kindergarten in the public schools to obtain a comprehensive eye examination conducted by a licensed optometrist or ophthalmologist. This section was later revised in Section 20 of Session Law 2005-345 to make technical changes and adjust a reporting date.

The comprehensive eye exam consists of a complete and thorough examination of the eye and human visual system and includes an evaluation, determination, and diagnosis of:

- Visual acuity at a distance and near
- Alignment and ocular motility
- Actual refractive errors
- Any color vision disorder
- Intraocular pressure
- Ocular health, including internal and external assessment

The Governor's Vision Care Program provides funds for eligible children in grades K-3 to reimburse optometrist and ophthalmologist for the comprehensive examination, including necessary spectacles. The Program is located in the Department of Health and Human Services, Division of Public Health and is administered by the Governor's Commission on Early Childhood Vision Care, a six member commission comprised of three optometrist and three ophthalmologist appointed by the Governor, The Speaker of the House, and the President Pro Tempore of the Senate.

BILL ANALYSIS: House Bill 2699 amends the current law by making the following modifications:

Beginning in the 2007-2008 school year,

Section 1 requires the Governor's Commission on Early Childhood Vision Care to adopt standards for vision care screenings. Children entering kindergarten are required to obtain a vision screening conducted by licensed physician, optometrist, physician assistant, nurse practitioner, registered nurse, orthoptist, or a vision screener certified by Prevent Blindness North Carolina Board. The parent/guardian/person standing in loco parentis (parent) of the child has 180 days from the start of the school year to present a standard certificate verifying the screening has been performed within the past 12 months. This requirement applies to students who enter 1st grade without having been enrolled in kindergarten. A comprehensive eye exam is required for students who receive but fails to pass a vision screening. Appropriate school personnel may recommend to a child's parent/guardian that the student have a comprehensive eye exam. Notification to the parent/guardian must include information about funds the Commission may have available to assist in paying for the exam and corrective lenses.

Comprehensive eye exams are to be conducted by a duly licensed optometrist or ophthalmologist. The results of the exam are to be included on the proper transmittal form and the parent shall submit the form to the school. The exam will consist of a thorough examination of the eye and the following:

- Measurement of visual acuity
- Ocular alignment and motility
- Depth perception-steropsis
- Fusion
- Slit lamp examination of the lid margins, conjunctivae, corneas, anterior chamber, iris, and crystalline lens
- Examination of ocular adnexa, the anterior segment and pupils
- Cyclopegic refraction and dilated fundus examination.

No child will be excluded from attending kindergarten for failure to obtain a comprehensive eye exam.

Section 2(a) changes the membership of the Commission on Early Childhood Vision Care from 6 to 10 members The Governor appoints-4 optometrists, 2 opthalmologists, (of which one must be a currently serving member of the Prevent Blindness North Carolina Board), 1 pediatrician with a family practice or a family physician who provides services to children, and 1 school nurse who is certified by the Prevent Blindness North Carolina Board. The appointments made by the Speaker of the House of Representatives and the President pro-Tempore of the Senate remain the same.

Section 2(b) requires the Department of Health and Human Services, Division of Public Health to compile data on children receiving comprehensive eye exams and report the results annually to the Governor's Commission on Early Childhood Vision Care, the Fiscal Research Division, the House Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services. The Commission is required by section 2(a) to prepare information (disclaimer) for providers of vision screenings to give to parents/guardians of screening recipients. Section 2(c) directs the Commission to work with the Department of Public Instruction to establish procedures for identifying and referring children who need a screening or exam.

Section 3 authorizes the Division of Public Health, from funds appropriated for the 2006-2007 fiscal year, to reimburse providers for comprehensive exams and corrective lenses provided to eligible families. The section directs the Division to work with the Commission to establish procedure for reimbursements and directs the Commission to establish procedures to inform parents about applying and qualifying for vision care services.

Section 4 allows the Department to use up to 5% of funds appropriated to the Vision Care Program for operations and expenses.

Section 5 allows the Commission to adopt rules to implement the act.

Section 6 deems children that have received vision screenings prior to the availability of forms to have obtained the required screening.

EFFECTIVE DATE: This act is effective when it becomes law.

H2699e3-SMSQ

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 2699

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

H2699-ASQ-35 [v.1]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
Third Edition

Senator _____

moves to amend the bill on page 1, line 13, by deleting the word "passed" and substituting the word "obtained";
and on page 1, line 26, by deleting the word "that" and substituting the word "who".

SIGNED Walter R Purnell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 2699

AMENDMENT NO. 2
(to be filled in by
Principal Clerk)

H2699-ASQ-36 [v.2]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
Third Edition

Senator _____

moves to amend the bill on page 4, lines 31-38, by rewriting the lines to read:

" **SECTION 2.(c)** The Department of Health and Human Services, Division of Public Health, shall study and determine the feasibility of compiling data on the number of children who received comprehensive eye examinations, the types of problems found, and treatments provided, and shall report its findings to the Governor's Commission on Early Childhood Vision Care, the Joint Legislative Health Care Oversight Committee, the House of Representatives Appropriations Subcommittee on the Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than July 1, 2007.".

SIGNED William N Purnell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 2699

Committee Substitute Favorable 7/6/06
Third Edition Engrossed 7/6/06
PROPOSED SENATE COMMITTEE SUBSTITUTE H2699-PCS10650-SQ-75

Short Title: Vision Care Program Changes. (Public)

Sponsors:

Referred to:

May 25, 2006

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE VISION CARE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 130A-440.1 reads as rewritten:

"**§ 130A-440.1. ~~Comprehensive eye examination required.~~Early Childhood Vision Care.**

(a) Vision Screening Required for Children Entering Kindergarten. – Every child in this State entering kindergarten in the public schools, beginning with the 2007-2008 school year, shall obtain ~~a~~ vision screening in accordance with vision screening standards adopted by the Governor's Commission on Early Childhood Vision Care. Within 180 days of the start of the school year, the parent of the child shall present to the school principal or the principal's designee certification that the child has, within the past 12 months, obtained vision screening conducted by a licensed physician, optometrist, physician assistant, nurse practitioner, registered nurse, orthoptist, or a vision screener certified by Prevent Blindness North Carolina, or a comprehensive eye examination performed by an ophthalmologist or optometrist. The health assessment transmittal form required pursuant to G.S. 130A-440 qualifies as certification that the child has obtained the required vision screening. All providers conducting vision screening shall provide each parent in writing the results of the vision screening on forms bearing the signature of the provider supplied to the provider by the Governor's Commission on Early Childhood Vision Care. The provider shall also orally communicate this information to the parent and shall take reasonable steps to ensure that the parent understands the information communicated. In the instance where a child enters the first grade without having been enrolled in a kindergarten program requiring a vision screening, the requirements for vision screening under this subsection shall apply.

(a1) Comprehensive Eye Examination. – For children who receive and fail to pass a vision screening as required under subsection (a) of this section, a comprehensive eye examination is required. If a public school teacher, administrator, or other appropriate school personnel has reason to believe that a child enrolled in kindergarten through third grade is having problems with vision, the school personnel may recommend to the child's parent that the child have a comprehensive eye examination. Notification to the parent shall also inform the parent that funds may be available from the Governor's Commission on Early Childhood Vision Care to pay providers for the examination, including corrective lenses.

~~(b) The comprehensive eye examination required under this section shall be conducted by an optometrist or ophthalmologist licensed to practice in this State. No child shall attend kindergarten unless a comprehensive eye examination transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the comprehensive eye examination required by this section, is presented to the school principal, except in cases where the child has moved to North Carolina within the 60 days immediately preceding school entry, in which case the child shall have 60 days from the date of school entry to submit the eye examination transmittal form required under this section. In the event a child is unable to obtain services after the 60-day period has elapsed, the principal shall report this information to the Commission so that the Commission may identify alternative ways to provide services to these children.~~The comprehensive eye examination shall be conducted by a duly licensed optometrist or ophthalmologist. The comprehensive eye examination conducted pursuant to this section shall consist of a complete and thorough examination of the eye and shall include: ~~human visual system that includes an evaluation, determination, and diagnosis of:~~

(1) Measurement of visual acuity;
(2) Ocular alignment and motility;
(3) Depth perception – stereopsis;
(4) Fusion;
(5) Slit lamp examination of the lid margins, conjunctivae, cornea, anterior chamber, iris, and crystalline lens;
(6) Examination of the ocular adnexa, the anterior segment, and pupils; and
(7) Cycloplegic refraction and dilated fundus examination.
~~(1) Visual acuity at distance and near;~~
~~(2) Alignment and ocular motility;~~
~~(3) Binocular fusion abnormalities, including tracking;~~
~~(4) Actual refractive errors, including verification by subject means;~~
~~(5) Any color vision disorder;~~
~~(6) Intraocular pressure as may be medically appropriate; and~~
~~(7) Ocular health, including internal and external assessment.~~

Health assessment vision screening under G.S. 130A-440 ~~does not meet the requirements of this section.~~is not a comprehensive eye examination for purposes of this section.

(c) The results of a comprehensive eye examination conducted under this section shall be included on the ~~The~~ comprehensive eye examination transmittal form developed by the Commission pursuant to G.S. 143B-216.75 and shall contain a summary of the comprehensive eye examination performed by the optometrist or ophthalmologist. Any treatment recommendations by the optometrist or ophthalmologist, such as spectacles for schoolwork, shall appear in the summary and school health card. The provider shall present a signed transmittal form to the parent upon completion of the examination. The parent shall submit the transmittal form to the school in accordance with this section.

~~(d) This section shall not apply to children entering kindergarten in private church schools, schools of religious charter, or qualified nonpublic schools regulated by Article 39 of Chapter 115C of the General Statutes.~~

(e) G.S. 130A-441, 130A-442, and 130A-443, pertaining to health assessments, apply to comprehensive eye examinations required under this section.

(f) No child shall be excluded from attending school for a parent's failure to obtain a comprehensive eye examination required under this section. If a parent fails or refuses to obtain a comprehensive eye examination or to provide the certification of a comprehensive eye examination, the school shall send a written reminder to the parent of required eye examinations and shall include information about funds that may be available from the Governor's Commission on Early Childhood Vision Care.

(g) In adopting standards for vision screening under this section and as required under G.S. 130A-440, the Commission shall take into account the resources necessary to comply with the standards and, if standards will require additional resources, shall mitigate the impact on resources without compromising vision screening effectiveness.

(h) As used in this section, the term "parent" means the parent, guardian, or person standing in loco parentis."

SECTION 1.(b) G.S. 130A-440 reads as rewritten:

"(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. The health assessment may also include dental screening and developmental screening for cognition, language, and motor function."

SECTION 2.(a) G.S. 143B-216.75 reads as rewritten:

"(a) There is established the Governor's Commission on Early Childhood Vision Care ("Commission"). The Commission shall be located in the Department of Health and Human Services for administrative and budgetary purposes only.

(b) The Commission shall consist of ~~six~~ 10 members appointed as follows:

(1) ~~Two optometrists and two ophthalmologists,~~Four optometrists, two ophthalmologists, and one general pediatrician or a family physician who provides services to children, each of whom is licensed to practice in this State, and one school nurse who is certified by the Prevent Blindness North Carolina Board, appointed by the ~~Governor;~~Governor. Among the optometrists and ophthalmologists appointed by the

Governor, one shall be a currently serving member of the Prevent Blindness North Carolina Board;

(2) One optometrist licensed to practice in this State appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives; and

(3) One ophthalmologist licensed to practice in this State appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.

The initial members appointed by the General Assembly shall each serve a one-year term. The initial members appointed by the Governor shall each serve a two-year term. Subsequent appointments shall be for three-year terms. Vacancies shall be filled by the original appointing authority.

(c) The Commission shall adopt rules to implement and administer the Governor's Vision Care Program established under this section. The rules shall address:

(1) Accepting and processing of applications by families for Program services.

(2) ~~Verification~~ Establishment and verification of applicant income eligibility.

(3) Reimbursement to providers for services provided to eligible participants.

(4) Informing providers and the general public about the Program.

(5) Other duties necessary to implement the purposes and requirements of this ~~section.~~section, including the development of a comprehensive eye examination transmittal form required under G.S. 130A-440.1.

The Commission shall develop alternative ways for providing services to children who qualify for the Program when funding for Program services has been exhausted.

The Commission shall prepare written information for providers conducting vision screening. The written information shall state, in effect: 'Vision screening is not a substitute for a comprehensive eye examination.' The Commission shall provide copies of this information to providers so that the provider may give a copy to the parent, guardian, or person standing in loco parentis."

SECTION 2.(b) The Governor's Commission on Early Childhood Vision Care shall work with the Department of Public Instruction to establish procedures for identifying and referring children who need vision screening or a comprehensive eye examination as required by G.S. 143B-216.75.

SECTION 2.(c) The Department of Health and Human Services, Division of Public Health, shall study and determine the methodology of compiling data on the number of children who received comprehensive eye examinations, the types of problems found, and treatments provided, and shall report its findings to the Governor's Commission on Early Childhood Vision Care, the Joint Legislative Health Care Oversight Committee, 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 not later than July 1, 2007.

SECTION 2.(d) Section 10.59F(b) of S.L. 2005-276, as amended by Section 20(b) of S.L. 2005-345, is repealed.

SECTION 3. Funds appropriated to the Department of Health and Human Services, Division of Public Health, for the 2006-2007 fiscal year shall be used to reimburse providers for comprehensive eye examination services, including corrective lenses, provided to eligible families. The Division of Public Health shall work with the Governor's Commission on Early Childhood Vision Care to establish procedures for reimbursing providers. Eligibility requirements for reimbursement shall be as provided under G.S. 143B-216.75. The Governor's Commission on Early Childhood Vision Care shall establish procedures to inform parents about applying and qualifying for vision care services.

SECTION 4. The Department of Health and Human Services may use up to five percent (5%) of the funds appropriated for the Vision Care Program for the 2006-2007 fiscal year for Program operations and Commission expenses.

SECTION 5. The Governor's Commission on Early Childhood Vision Care may adopt temporary rules in accordance with G.S. 150B-21.1 to implement this act.

SECTION 6. Children who have received vision screenings prior to the availability of forms developed by the Governor's Commission on Early Childhood Vision Care in accordance with G.S. 130A-440.1 shall be deemed to have obtained the screening required under G.S. 130A-440.1, as amended by this act.

SECTION 7. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 18, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jami Fitzgerald	NC Family Policy Council
Lauren Rogers	NC Family Policy Council
Deborah Rowe	NCPHA/ NCALHD
Theresa Kosfrzewa	SSG NC
Russ Dubisky	SSG- NC
[illegible]	PIFC

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 18, 2006**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Henry Jones	Atty Raleigh
Eric Sauls	Edmisten + Webb
ANN LORE	DUHS
Simone Porter	DUHS
Sarah Holloway	DUHS
Marcus Downs	NC State Health Plan
[signature]	NCLM
Holly Bryan	NCATL
Chris Medlin	NCATL
Tom Vaughan	ACF
Daphne Lyons	OSBM
[signature]	NCSEPS

VISITOR REGISTRATION SHEET

Health and Human Resources — **July 18, 2006**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charlene Carey	NC Right to Life
Alan Skipper	NC Medical Society
Leane Womin	NCSBA
Jennifer Kabat	Planned Parenthood
Molly Ryan	NCSBA
Kari Johnson	Smith Anderson
Joanne Steven	Steven
Janet Gray	NCANA
Susan Harrison	WCPSS
Katherine Joyce	NCASA
Rebecca Troutman	NCACC

AGENDA

SENATE HEALTH CARE COMMITTEE
July 19, 2006, 15 Minutes after Session
Room 544, Legislative Office Building

I. Welcome and Opening Remarks

II. Introduction of Pages

III. Bill to be Considered

- **HB 1860 Stroke Advisory Council** — **Rep. Faison**, **Rep. England, M.D.**, **Rep. Nye**, **Rep. Wright**

IV Other Business

V. Adjournment

`SENATE HEALTH CARE COMMITTEE
Wednesday, July 19, 2006
2:50 P.M.
Senator Purcell's Desk, Senate Chamber

MINUTES

The Senate Health Care Committee met at 2:50 P.M. on Wednesday, July 19, 2006, in the Senate Chamber around Senator Purcell's desk, with twelve members present. Senator Purcell presided.

H.B 1860, *Stroke Advisory Council*, was considered, with a Proposed Committee Substitute presented. and approved for discussion by the Committee. Senator Dorsett noted that the Council did not include an African-American, and suggested an amendment to include a member of the North State Medical Society. The amendment was voted upon and passed, and rolled into a new PCS. The bill passed as amended.

The meeting adjourned at 3:00 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 CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, July 19, 2006

Senator PURCELL,
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) **1860** Stroke Advisory Council.

Draft Number:	PCS50779
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 4

HOUSE BILL 1860

Corrected Copy 5/16/06
Committee Substitute Favorable 7/6/06
Committee Substitute #2 Favorable 7/11/06

Short Title: Stroke Advisory Council. (Public)

Sponsors:

Referred to:

May 10, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ESTABLISH AND APPOINT A STROKE ADVISORY COUNCIL.

Whereas, stroke is one of the leading causes of long-term disability; and

Whereas, as many as twenty-five percent of stroke survivors are permanently disabled; and

Whereas, stroke is the third leading cause of death in North Carolina; and

Whereas, North Carolina is situated in the country's "Stroke Belt," with North Carolina ranking fourth in the nation for stroke-related death; and

Whereas, 5,000 North Carolinians die of stroke each year; and

Whereas, nearly thirty percent of all people who have strokes are younger than 65 years of age; and

Whereas, as the population of North Carolina ages, death and disability from stroke will increase dramatically if this State does not implement strategies based on sound research that will improve the outcomes of stroke victims across this State; and

Whereas, the Institute of Medicine of the National Academy of Science has recommended the establishment of coordinated systems of care as a means of improving the level of medical treatment that patients receive; and

Whereas, in agreement with the Institute of Medicine report, national medical experts from a wide range of disciplines have concluded that improving the organization of stroke care through the development of statewide stroke care systems offers one means of reducing the burden of stroke on a community basis; and

Whereas, there has not been an appreciable change in the organization of stroke care in the State over recent years; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-509 is amended by adding the following new subdivision to read:

"**§ 143-509. Powers and duties of Secretary.**

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, shall accomplish all of the following:

...

"(13) Establish and maintain a Stroke Advisory Council, which shall advise the Secretary regarding the development of a statewide system of stroke care that shall include, among other items, a system for identifying and disseminating information about the location of primary stroke centers. The Secretary shall appoint the members of the Stroke Advisory Council as follows:

a. Three physicians, one upon the recommendation of the North Carolina Medical Society, one upon the recommendation of the North Carolina College of Emergency Physicians, and one who specializes in the treatment of strokes.

b. A hospital administrator recommended by the North Carolina Hospital Association.

c. A representative from the American Heart Association.

d. A representative from the North Carolina Association of Rescue and Emergency Medical Services.

e. Other relevant experts as the Secretary deems beneficial to achieve the goals of the Stroke Advisory Council."

SECTION 2. Not later than February 15, 2007, the Department of Health and Human Services shall report to the Joint Legislative Commission on Governmental Operations, 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 on the development of a statewide system of stroke care.

SECTION 3. Notwithstanding any other provision of law to the contrary, the members of the Stroke Advisory Council shall, for the 2006-2007 fiscal year only, serve without compensation and without reimbursement for travel, food, and lodging.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1860

Corrected Copy 5/16/06
Committee Substitute Favorable 7/6/06
Committee Substitute #2 Favorable 7/11/06
PROPOSED SENATE COMMITTEE SUBSTITUTE H1860-CSSQ-76 [v.1]

7/19/2006 11:15:03 AM

Short Title: Stroke Advisory Council. (Public)

Sponsors:

Referred to:

May 10, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE TO ESTABLISH AND APPOINT A STROKE ADVISORY COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-216.60 is amended by adding the following new subdivision to read:

"**§ 143B-216.60. The Justus-Warren Heart Disease and Stroke Prevention Task Force.**

...

(j) The Task Force has the following duties:

...

(10) Establish and maintain a Stroke Advisory Council, which shall advise the Task Force regarding the development of a statewide system of stroke care that shall include, among other items, a system for identifying and disseminating information about the location of primary stroke centers."

SECTION 2. The Justus-Warren Heart Disease and Stroke Prevention Task Force shall appoint the members of the Stroke Advisory Council as follows:

(1) Three physicians, one upon the recommendation of the North Carolina Medical Society, one upon the recommendation of the North Carolina College of Emergency Physicians, and one who specializes in the treatment of strokes.

(2) A hospital administrator recommended by the North Carolina Hospital Association.

(3) A representative from the American Heart Association.
(4) A representative from the North Carolina Association of Rescue and Emergency Medical Services.
(5) A representative from the Area Health Education Centers (AHEC).
(6) Other relevant experts as the Task Force deems beneficial to achieve the goals of the Stroke Advisory Council.

SECTION 3. Not later than February 15, 2007, the Justus-Warren Heart Disease and Stroke Prevention Task Force shall report to the Joint Legislative Commission on Governmental Operations, 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 on the findings and recommendations of the Stroke Advisory Council regarding the development of a statewide system of stroke care.

SECTION 4. Notwithstanding any other provision of law to the contrary, the members of the Stroke Advisory Council shall, for the 2006-2007 fiscal year only, serve without compensation and without reimbursement for travel, food, and lodging.

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1860:
Stroke Advisory Council

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 19, 2006
Introduced by:	Reps. Faison, Nye, Wright, England	**Summary by:**	Shawn Parker
Version:	PCS to Fourth Edition H1860-CSSQ-76		Legislative Analyst

SUMMARY: ***The Senate Proposed Committee Substitute directs the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish and appoint a Stroke Advisory Council.***

(House Bill 1860v.3 directed the Secretary of Health and Human Services to establish and appoint this Council.)

BILL ANALYSIS:

The Committee Substitute directs the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish and maintain a Stoke Advisory Council. The Council will advise the Task Force regarding the development of a statewide system of stroke care.

The Task Force shall appoint the following members:

- 3 physicians- one recommended by the NC Medical Society, one recommended by the NC College of Emergency Physicians, and one who specializes in the treatment of strokes;
- A hospital administrator recommended by the North Carolina Hospital Association;
- A representative of the American Heart Association;
- A representative from the North Carolina Association of Rescue and Emergency Medical Services;
- A representative from the Area Health and Education Centers (AHEC); and
- Any other relevant experts.

The Task Force shall report to the Joint Legislative Commission on Governmental Operations, 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 on the development of a statewide system of stroke care by February 15, 2007.

Not withstanding any other provision of law, the members of the Stroke Advisory Council will serve for the 2006-2007 fiscal year without compensation or reimbursement.

EFFECTIVE DATE: This act is effective when it becomes law.

H1860e4-SMSQ-CSSQ-76

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 5

HOUSE BILL 1860

Corrected Copy 5/16/06
Committee Substitute Favorable 7/6/06
Committee Substitute #2 Favorable 7/11/06
Senate Health Care Committee Substitute Adopted 7/19/06

Short Title: Stroke Advisory Council. (Public)

Sponsors:

Referred to:

May 10, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE TO ESTABLISH AND APPOINT A STROKE ADVISORY COUNCIL.

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...

(10) Establish and maintain a Stroke Advisory Council, which shall advise the Task Force regarding the development of a statewide system of stroke care that shall include, among other items, a system for identifying and disseminating information about the location of primary stroke centers."

SECTION 2. The Justus-Warren Heart Disease and Stroke Prevention Task Force shall appoint the members of the Stroke Advisory Council as follows:

(1) Four physicians, one upon the recommendation of the North Carolina Medical Society, one upon the recommendation of the North Carolina College of Emergency Physicians, one upon the recommendation of the Old North State Medical Society, and one who specializes in the treatment of strokes.

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(4) A representative from the North Carolina Association of Rescue and Emergency Medical Services.
(5) A representative from the Area Health Education Centers (AHEC).
(6) Other relevant experts as the Task Force deems beneficial to achieve the goals of the Stroke Advisory Council.

SECTION 3. Not later than February 15, 2007, the Justus-Warren Heart Disease and Stroke Prevention Task Force shall report to the Joint Legislative Commission on Governmental Operations, 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 on the findings and recommendations of the Stroke Advisory Council regarding the development of a statewide system of stroke care.

SECTION 4. Notwithstanding any other provision of law to the contrary, the members of the Stroke Advisory Council shall, for the 2006-2007 fiscal year only, serve without compensation and without reimbursement for travel, food, and lodging.

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

SESSION LAW 2006-197
HOUSE BILL 1860

AN ACT TO DIRECT THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE TO ESTABLISH AND APPOINT A STROKE ADVISORY COUNCIL.

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"**§ 143B-216.60. The Justus-Warren Heart Disease and Stroke Prevention Task Force.**

...

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SECTION 4. Notwithstanding any other provision of law to the contrary, the members of the Stroke Advisory Council shall, for the 2006-2007 fiscal year only, serve without compensation and without reimbursement for travel, food, and lodging.

SECTION 5. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 20th day of July, 2006.

s/ Beverly E. Perdue
President of the Senate

s/ James B. Black
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 2:02 p.m. this 3rd day of August, 2006