2007-2008

SENATE HEALTH CARE COMMITTEE

MINUTES

Senate Health Care Committee
Wednesday, March 7, 2007, 11:00 AM
Room 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 164	Study Housing/Training Mentally Ill in ACH.	Senator Allran
SB 199	Accessible Electronic Info Act/Blind/Disabled.	Senator Dorsett
SB 110	Medicaid Income Limits Level Study.	Senator Malone
SB 56	Penalty Review Committee Changes.	Senator Bingham
SB 58	Special Assistance In-Home Assign.	Senator Bingham

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, March 7, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, March 7, 2007, in Room 544 of the Legislative Office Building, with sixteen members present, and Senator William R. Purcell presiding. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present, recognized the new members, and introduced the pages and sergeants-at-arms.

Senator Purcell asked Senator Bingham to present his bill, SB58, *Special Assistance in-Home Assign.* Senator Kinnaird asked if it necessary to have a CAP slot under terms of this bill. Susanne Merrill of the Division of Aging and Adult Services said that it is similar to the CAP program, and that there are 1500 slots available under the terms of this bill; and that an individual could receive up to 75% of the cost of being placed in an adult care home. Senator Dannelly moved for a favorable report. The bill will be re-referred to Appropriations.

Senator Allran spoke to his bill, SB 164, *Study Housing/Training Mentally Ill in ACH.* A PCS was adopted. Senator Forrester moved for a report unfavorable as to the original bill, but favorable as to the PCS.

Senator Purcell called on Senator Dorsett to present her bill, SB 199, *Accessible Electronic Info Act/Blind/Disabled.* Senator Blake asked how the needed equipment is distributed to those who need it, and Senator Dorsett replied that this is done through the libraries. Senator Dannelly moved for a favorable report.

Senator Malone presented his bill, SB 110, *Medicaid Income Limits Level Study.* Senator Dorsett moved for a favorable report, and this bill will be re-referred to Appropriations.

Senator Bingham presented his bill, SB 56, *Penalty Review Committee Changes.* Senator Dannelly asked how many times this committee would meet, and Mr. Ben Popkin responded that the bill called for once each quarter. Senator Dorsett moved for a favorable report.

The meeting adjourned at 9:47 A.M.

William R. Purcell

Senator William R. Purcell, Co-Chair

Stan Bingham

Senator Stan Bingham, Co-Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, March 07, 2007

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

FAVORABLE

S.B. **56** Penalty Review Committee Changes.
Sequential Referral: None
Recommended Referral: None

S.B. **58** Special Assistance In-Home Assign.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

S.B. **110** Medicaid Income Limits Level Study.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

S.B. **199** Accessible Electronic Info Act/Blind/Disabled.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

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

S.B. **164** Study Housing/Training Mentally Ill in ACH.
Draft Number: 35157
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 5

Committee Clerk Comments:

SENATE BILL 56:
Penalty Review Committee Changes

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 6, 2007
Introduced by:	Sen. Bingham	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 56 amends the Penalty Review Committee process to require that the Committee meet as frequently as needed, but not less than once per quarter, to review administrative penalties assessed; to require both public notice and direct notice of meetings, and to require providers to post the meeting notice in a conspicuous place; to allow individuals, lawfully designated by residents, to receive notice; and to require each Committee member to attend a training program. This bill is a recommendation by the North Carolina Study Commission on Aging.***

[As introduced, this bill was identical to H94, as introduced by Reps. Weiss, Earle, Bordsen, England, which is currently in House Aging .]

CURRENT LAW:

S.L. 2005-276, Section 10.40A(l), amended the Penalty Review Committee (PRC) process in G.S. 131D-34(h) to require that the Committee: 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. This current law also requires the Department to notify residents affected, and the families or guardians of residents affected, of the right to request a review of the Department's penalty decision before the decision becomes final and further requires the Penalty Review Committee to meet to conduct the review and inform the family member or guardian of the results within 60 days of the receipt of a review request.

The recently amended current law requires notification of the families or guardians of the residents affected. However, due to the laws regulating the release of healthcare and personal information, the Department was advised by the Attorney General's office that informed consent was needed for release of information to the family unless the family member is a legal guardian or has Power of Attorney (POA) for the resident. As a result, the statutory changes became more difficult and time consuming to implement. Additionally, the changes in S.L. 2005-276 resulted in a decreased frequency of PRC meetings.

BILL ANALYSIS:

Senate Bill 56 amends the initial paragraph of G.S. 131D-34(h) to return it to the language that was in place prior to the changes enacted by S.L. 2005-276. The only change this bill makes to the language prior to 2005 is a clarification that the Penalty Review Committee (PRC) must meet no less frequently than once each quarter of the year. The bill also makes the following changes to G.S. 131D-34(h)(1):

- Requires that public notice be made via Web site.
- Requires that direct notice be made to the provider, who shall post the notice of the scheduled PRC meeting in a conspicuous place available to residents, family members, and the public.
- Replaces the requirement of providing direct notice to "families or guardians of the residents affected" with a requirement that direct notice be provided to "Those individuals lawfully designated by the affected resident to make health care decisions for the resident."

Additionally, Senate Bill 56 returns the language to G.S. 131D-34(h)(4b) that was deleted from G.S. 131D-34(h)(4) by S.L. 2005-276, and further deletes the language in G.S. 131D-34(h)(4a) that was added by S.L. 2005-276 because the overall process is essentially returning to the way it operated previously.

This act becomes effective October 1, 2007.

BACKGROUND:

This bill is a recommendation from the North Carolina Study Commission on Aging. On October 25, 2006, the Commission heard a presentation on the Penalty Review Committee (PRC) process by representatives from the Division of Facility Services, Department of Health and Human Services. The Department suggested that the PRC process be amended to delete the semiannual meeting requirements; to provide public notice of meetings via the website; and to require the licensed provider to post notices of a scheduled PRC meeting in a conspicuous place available to residents, family members and the public. During the presentation, Commission members expressed interest in notifying guardians and those with Power of Attorney for residents that are involved.

Theresa Matula, Legislative Analyst to House Aging, substantially contributed to this summary.

S0056e1-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 56*

Short Title:	Penalty Review Committee Changes.	(Public)
Sponsors:	Senators Bingham, Dannelly, Dorsett, Allran, Malone; Brunstetter, Forrester, Hartsell, Jones, Kinnaird, Stevens, and Swindell.	
Referred to:	Health Care.	

February 12, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE PENALTY REVIEW COMMITTEE PROCESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-34(h) reads as rewritten:

"(h) The Secretary shall establish a penalty review committee within the Department, which shall meet as often as needed, but no less frequently than once each quarter of the year, ~~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.~~ to review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129 as follows:

(1) The Secretary shall administer the work of the Committee and provide public notice of its meetings via Web site, and provide direct notice to the following parties involved in the penalties the Committee will be reviewing:

a. The licensed ~~provider;~~ provider, who upon receipt of the notice, shall post the notice of the scheduled Penalty Review Committee meeting in a conspicuous place available to residents, family members, and the public;

b. The local department of social services that is responsible for oversight of the facility involved;

c. The residents affected; and

d. ~~The families or guardians of the residents affected.~~ Those individuals lawfully designated by the affected resident to make health care decisions for the resident.

(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) Repealed by Session Laws 2005-276, s. 10.40A(l), effective July 1, 2005.

~~(4a) The Department of Health and Human Services shall notify families or guardians of affected residents of the right to request a penalty review committee review of the Department's penalty decision before the decision becomes final. Within 60 days of receipt of a request from a family member or guardian for review of the Department's penalty decision, the penalty review committee shall meet to conduct the review and shall inform the family member or guardian of the results of the review.~~

(4b) 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.

(6) 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."

SECTION 2. This act becomes effective October 1, 2007.

SENATE BILL 58:
Special Assistance In-Home Assign

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 1, 2007
Introduced by:	Sen. Bingham	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 58 would allow for funds appropriated to the Department of Health and Human Services for the 2007-2008 fiscal year to be used to increase the maximum number of assignments to the Special Assistance In-Home Program to 2,000 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.

This bill is a recommendation by the North Carolina Study Commission on Aging.

CURRENT LAW: Session Law 2006-156 authorized continuation and expansion of the Special Assistance In-Home Program from 1,000 to 1,500 assignments. Participation is voluntary on the part of the county departments of social services. 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

BILL ANALYSIS: Senate Bill 58 would allow the Department of Health and Human Services to use funds appropriated for the 2007-2008 fiscal year to increase the maximum number of assignments to the special assistance in-home program to 2,000 persons.

EFFECTIVE DATE: This act would become effective July 1, 2007.

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 increasing the number of slots to 800.

Session Law 2005-276 increased the maximum number of assignments 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.

Session Law 2006-156 increased the maximum number of assignments to 1,500.

S0058e1-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 58*

Short Title:	Special Assistance In-Home Assign.	(Public)
Sponsors:	Senators Bingham, Dannelly, Dorsett, Allran, Malone; Forrester, Hartsell, Jones, Kinnaird, Stevens, and Swindell.	
Referred to:	Health Care.	

February 12, 2007

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, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Funds appropriated to the Department of Health and Human Services for the 2007-2008 fiscal year may be used to increase the maximum number of assignments to special assistance in-home program to 2,000 persons.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 110*

Short Title:	Medicaid Income Limits Level Study.	(Public)
Sponsors:	Senators Malone, Dannelly, Dorsett, Allran, and Bingham.	
Referred to:	Health Care.	

February 12, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW OPTIONS FOR INCREASING MEDICAID MEDICALLY NEEDY INCOME LIMITS, 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, Division of Medical Assistance, shall study the medically needy income standard. The study shall include determining a method for increasing the current standard while providing improved consistency across long-term care settings. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging not later than September 1, 2008.

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

SENATE BILL 110:
Medicaid Income Limits Level Study

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 6, 2007
Introduced by:	Sen. Malone	**Summary by:**	Shawn Parker Legislative Analyst
Version:	First Edition		

SUMMARY: ***Senate Bill 110 requires the Department of Health and Human Services, Division of Medical Assistance, to determine a method for increasing the Medicaid medically needy income standard while providing improved consistency across long-term care settings. This bill is a recommendation from the NC Study Commission on Aging.***

BILL ANALYSIS: Senate Bill 110 directs the Department of Health and Human Services (DHHS). Division of Medical Assistance to study the Medicaid medically needy income standard. As part of the study, the Division must determine a method for increasing the current standard while providing improved consistency across long-term care settings. The Department is required to report findings and recommendations to the NC Study Commission on Aging by September 1, 2008. **The act would become effective when it becomes law.**

BACKGROUND: The medically needy income limit has not been increased in a long time and has not been indexed for inflation. Concern for NC's medically needy income limit has been raised several times during the last six years. Recommendation #28, a priority item, from the 2001 Final Report from the NC Institute of Medicine Task Force on Long-Term Care, recommended that the General Assembly appropriate funds to increase the Medicaid medically needy income limits.

S.L. 2004-124, Section 10.3, required a study to identify whether NC policies favor support for individuals in institutional settings over support for individuals living at home. The NC Institutional Bias study was conducted by the Lewin Group and identified the following in Bias #3: "Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community while institutions provide room and board." The Lewin Group's recommendation was to increase the medically needy income standard from the current monthly standard of $242 to a level at least comparable to the national average SSI ($416 for a single individual.) A 2002 breakdown by state of medically needy income limits, showed that NC had the seventh lowest rate at $242, and the average rate among states was $416.

A DHHS report in response to S.L. 2006-110, indicated that there was consensus among stakeholders that while adjusting the medically needy income standard is an important goal for NC, it should not be at the expense of adequate funding for the existing service system. It was recommended that stakeholder concern about financial feasibility could be addressed by studying whether Medicaid can cover some rather than all services and the consideration of a phased adjustment of the standard over time. As such, the Commission recommended that the General Assembly require DHHS to study the medically needy income standard and determine the best method of increasing the standard while providing improved consistency across long-term care settings.

S0110e1-SMSQ

SENATE BILL 164:
Study Housing/Training Mentally Ill in ACH

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 6, 2007
Introduced by:	Sen. Allran	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 164 would direct the Department of Health and Human Services to study rules and regulations relating to the housing of individuals with mental illness in adult care homes that also house individuals without mental illness, and to study the need for training direct care workers in long-term care facilities to provide appropriate care to residents with mental illness and to residents without mental illness.***

The bill would direct the Department of Health and Human Services to present its findings and recommendations, including statutory or rule changes where required, in response to these studies to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008. This bill is a recommendation by the North Carolina Study Commission on Aging.

This act is effective when it becomes law.

[As introduced, this bill was identical to H196, as introduced by Reps. Earle, Weiss, Bordsen, England, which is currently in Rules, Calendar, and Operations of the House.]

BILL ANALYSIS: Senate Bill 164 would direct the Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to study and make recommendations regarding the following issues relating to the housing of individuals with mental illness in long-term care facilities with individuals without mental illness:

- Rules and regulations in North Carolina and other states regarding the provision of appropriate care and the housing of individuals with mental illness in the same facility with individuals without mental illness; and
- The need for training direct care workers in long-term care facilities to provide appropriate care to facility residents with mental illness and to facility residents without mental illness.

Senate Bill 164 would direct the Department of Health and Human Services to present its findings and recommendations in response to the studies authorized by the bill, along with any required statutory or rule changes, to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: During the last interim period, several members of the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services were appointed to a Subcommittee to explore issues relating to the housing of individuals with mental illness in long-term care facilities that also provide housing to individuals without mental illness. The Subcommittee met, heard presentations, and formulated recommendations, which are included in Senate Bill 164, to address issues identified.

S0164e1-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 164*
PROPOSED COMMITTEE SUBSTITUTE S164-PCS35157-RD-1

Short Title: Study Housing/Training Mentally Ill in ACH. (Public)

Sponsors:

Referred to:

February 14, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RULES AND REGULATIONS REGARDING HOUSING INDIVIDUALS WITH MENTAL ILLNESS IN THE SAME FACILITY VICINITY AS INDIVIDUALS WITHOUT MENTAL ILLNESS, AND TO RECOMMEND STAFF TRAINING REQUIREMENTS FOR DIRECT CARE WORKERS IN ADULT CARE HOMES TO PROVIDE APPROPRIATE CARE TO RESIDENTS WITH MENTAL ILLNESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study rules and regulations in North Carolina and other states regarding the provision of appropriate care and housing of individuals with mental illness in the same facility vicinity with individuals without mental illness and shall make recommendations relating to the housing of these individuals.

SECTION 1.(b) The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study the need for training direct care workers in adult care homes to provide appropriate care to facility residents with mental illness and facility residents without mental illness and shall make recommendations for appropriate training of these workers. The study shall address the fiscal impact that the implementation of training requirements would have on these facilities and the amount of funding needed to support a successful training model.

SECTION 1.(c) The Department of Health and Human Services shall present its findings and recommendations in response to the studies authorized in

subsections (a) and (b) of this section, along with any required statutory or rule changes, to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 164*

Short Title:	Study Housing/Training Mentally Ill in ACH.	(Public)
Sponsors:	Senators Allran, Dannelly, Dorsett, Bingham, Malone; and Jones.	
Referred to:	Health Care.	

February 14, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RULES AND REGULATIONS REGARDING HOUSING INDIVIDUALS WITH MENTAL ILLNESS IN THE SAME FACILITY VICINITY AS INDIVIDUALS WITHOUT MENTAL ILLNESS, AND TO RECOMMEND STAFF TRAINING REQUIREMENTS FOR DIRECT CARE WORKERS IN LONG-TERM CARE FACILITIES TO PROVIDE APPROPRIATE CARE TO RESIDENTS WITH MENTAL ILLNESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study rules and regulations in North Carolina and other states regarding the provision of appropriate care and housing of individuals with mental illness in the same facility vicinity with individuals without mental illness and shall make recommendations relating to the housing of these individuals.

SECTION 1.(b) The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study the need for training direct care workers in long-term care facilities to provide appropriate care to facility residents with mental illness and facility residents without mental illness, and shall make recommendations for appropriate training of these workers.

SECTION 1.(c) The Department of Health and Human Services shall present its findings and recommendations in response to the studies authorized in subsections (a) and (b) of this section, along with any required statutory or rule changes, to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

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

SENATE BILL 199:
Accessible Electronic Info Act/Blind/Disabled

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 5, 2007
Introduced by:	Sen. Dorsett	**Summary by:**	Shawn Parker Legislative Analyst
Version:	First Edition		

SUMMARY: ***Senate Bill 199 would appropriate $75,000 to the Department of Health and Human Services, Division of Services for the Blind, to maintain an electronic information service for blind and disabled persons. The bill creates a new Article in Chapter 168 of the General Statutes to govern this service.***

The bill becomes effective July 1, 2007.

BILL ANALYSIS: Senate Bill 199 would create a new Article in Chapter 168 of the General Statutes which would regulate a statewide accessible electronic information service. This service provides news and other timely information, including newspapers, 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.

The bill would appropriate seventy-five thousand dollars ($75,000) for the 2007-08 fiscal year to maintain this service.

CURRENT LAW AND BACKGROUND:

The General Assembly provided funds ($75,000) for accessible information services for blind and disabled persons in SFY 2005-06 and SFY 2006-07.

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. Use of the NCLBPH is free for users.

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.

EFFECTIVE DATE: This act becomes effective July 1, 2007.

S0199e1-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 199

Short Title:	Accessible Electronic Info Act/Blind/Disabled.	(Public)
Sponsors:	Senators Dorsett; Allran, Atwater, Berger of Franklin, Berger of Rockingham, Bingham, Brown, Clodfelter, Dalton, Dannelly, Garrou, Goss, Hoyle, Jenkins, Jones, Malone, Nesbitt, Preston, Purcell, Shaw, Stevens, Swindell, Tillman, and Weinstein.	
Referred to:	Health Care.	

February 19, 2007

A BILL TO BE ENTITLED

AN ACT TO MAINTAIN 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, that prevent them from using conventional print material.

(2) The State fulfills an important responsibility by providing books and magazines prepared in Braille, audio, and large-type formats made available to 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 2007-2008 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, 2007.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
Name of Committee

MARCH 7, 2007
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Polly Williams	Friends of Residents / Triangle OBL
Daniel Blum	Kennedy Covington
Dexter Joyner	AARP
Marie McBride	Senior Tar Heel Legislature
Mary H. Odom	AARP
Bill Wilson	AARP NC
Karen Gottovi	AARP
Shan	HHS
Becki Gray	John Locke Foundation
Lou Wilson	NCALTCF

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
Name of Committee

MARCH 7, 2007
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Deanna Jessup	NCUC - Public Staff
Lu-Ann Hedgepeth	NCPA
John McMillan	NFIB
Joy Peters	JP Assoc
John Bowdish	Astra Zeneca
Jamie Ward	JP, AL, PA
Jerry Kaplan	HK & McGuire Woods
John Rustin	NC Family Policy Council
Jami Fitzgerald	NC " " "
Catie Blair	" "
Ernie Zapetis	DFS - Adult Care Licensure

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
Name of Committee

MARCH 7, 2007
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gary Cyrus	Aging / Adult Services
Christine Wunsche	106 - Daily Bulletin
K Wright	BCBSNC
TOMMY SUTER	WYETH
Roger Bone	Bone & Assoc
Ericka Shearin	622 LOB Sen. D Berger's Intern
Susan Ryan	Division of Medical Assistance
Angela Floyd	Div of Med Assistance
Jill Hinton Keel	Autism Society of NC
Abby C. Emanuelson	NMSS
Gary Ray	NFB

Senate Health Care Committee
Wednesday, March 14, 2007, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 260	**Schools Provide Info on Cervical Cancer.**	**Senator Dorsett**
SB 42	**Justus-Warren Task Force Recommendations.**	**Senator Purcell**
SB 474	**Reduce Perinatal Mortality and Disease.**	**Senator Purcell**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, March 14, 2007 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, March 14, 2007, in Room 544 of the Legislative Office Building, with sixteen members present. Senator Stan Bingham, Co-Chair 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 were several people to be introduced in the audience. First being the Orange, Durham, and Chatham Counties League of Women Voters. Next Senator Purcell introduced several Doctors from the NC Orthopedic Society and the NC Pediatric Society.

Senator Bingham asked for a motion to discuss the Proposed Committee Substitute for SB 260, ***Schools Provide Information on Cervical Cancer***. Senator Hagan offered the motion, which passed. Senator Dorsett was recognized to explain her bill. She stated the bill is about cancer prevention, stating it was an education and information bill. Senator Dorsett pointed out the bill would require information about Cervical Cancer, Cervical Dysplasia, Human Papillomavirus, and the vaccines available to prevent these diseases, be made available to public schools, private religious schools, qualified nonpublic schools, and home schools. She stated the bill further required information to be distributed to parents of children enrolled in public schools, grades 5 – 12, at the beginning of the school year. The American Cancer Society records over 11,000 cases of invasive cervical cancer in the US each year and about 4,000 of those individuals die. Sen. Dorsett presented data about Michigan, Florida, Illinois, Indiana, Virginia, Texas, and New Mexico, who have introduced legislation to vaccinate their students. She reiterated that SB 260 was only education and information. Sen. Dorsett asked to have a few people to make some comments about the bill. Dr. Tayloe, a Pediatrician from Goldsboro, stated that 80% of women in their 50's have had an HPV exposure. He also stated that 90% of cervical cancer could be eradicated with the vaccination. Dr. Suzanna Martin, a Pediatrician from Duke, stated the biggest problem is the cost, however given the amount of cervical cancer that this vaccine could prevent Dr. Martin recommended any and all education be given to all North Carolinians. Dr. Kevin Ryan, with the Division of Public Health, stated that the education material was needed in order for people to make an informed decision and that the department strongly recommended the vaccine. Phyllis West, senior assistant to the State Superintendent of Public Instruction, spoke on behalf of Superintendent June Atkinson and conveyed her support for SB 260. Senator Dr. Forrester pointed out that in the bill the information was for girls' parents only and he felt it should include boys and their parents also. Sen. Dr. Forrester also asked if minors could give consent for receipt of the HPV vaccine. Dr. Kevin Ryan responded that a minor could give consent for issues relating to the preventions of sexually transmitted diseases. This vaccine is a means of preventing sexually transmitted disease; therefore minors could consent for this vaccine. Sen. Hagan

asked if there was a vaccine for males. Dr. Kevin Ryan stated that clinical trials are in process. Sen. Dr. Forrester asked how long the vaccine is effective. Dr. Ryan said the studies are inconclusive, it is currently known to be effective for 5 years. Sen. Malone asked if insurances would pay for the vaccine, stating if they do not and no one can figure a way to get it to poor people then it is a lost cause. Dr. Dave Taylor, Jr. a Pediatrician from Goldsboro stated the vaccine would be paid for all children in the Medicaid Program. Private insurance companies are covering it also. It is part of the quality assurance standards at the Federal level; however, it may not cover the cost of the office visit, only the vaccine. The biggest problem will be young ladies who are too old to be in the Medicaid program, which is, up to 26 years old; they may not have any insurance. Sen. Brunstetter asked if there were other diseases and programs for which the state required information to be disseminated, how this information would be disseminated, and what kind of burden it would put on the system. Sen. Dorsett said other information has already been disseminated. Dr. Ryan responded that DHHS prepared the appropriated information and provided it to the Department of Public Instruction. He also stated the process was not challenging. Sen. Kinnaird suggested having the high school students to text message each other, expressing it would get around pretty fast. Following the point that Dr. Taylor made about the gap in the children who will not have insurance coverage, Sen. Kinnaird stated there would be none of these problems being mentioned if universal health coverage were available. Sen. Dannelly raised the question about the bill being only for females. He does not want the males left out, however, at the appropriate time he moved for a favorable report. Senator Nesbitt proposed to delete the word female, explaining then the bill would be for everyone. An amendment was prepared deleting the word female and Senator Nesbitt moved to pass the amendment, which passed unanimously. Senator Purcell moved to roll the amendment into a New PCS. The bill passed unanimously.

Sen. Bingham recognized Sen. Dr. Purcell to present SB 42, ***Justus-Warren Task Force Recommendations.*** Sen. Dannelly made the motion to hear the Proposed Committee Substitute, which passed. Sen. Dr. Purcell stated that the bill came from the Justus-Warren Heat Disease and Stroke Prevention Task Force which was formed by the General Assembly in 1995 and was named in honor of the late Rep. Larry Justus and Sen. Ed Warren who both worked hard in the heart disease and stroke area. This bill was developed by the Stroke Advisory Committee Council, which was established by the Justus-Warren Task Force. Stroke is the third leading cause of death in NC. In 2004 there were 4,949 deaths reported from strokes. Eastern counties of NC, SC, and Georgia have the highest death rate from stroke in the United States and have had for the last thirty years, the so-called Stroke Belt. A telephone survey in 2005 revealed there were 180,000 people living at home in NC who have had a history of stroke. Basically the bill in section one states that the Justus-Warren Heart Disease and Stroke Prevention Task Force will work with Health Care Providers across the state to establish a system of regionally distributed and locally determined stroke care networks for the state. Section two is the Appropriations for this bill. Dr. David Wong, Neurologist for UNC-Chapel Hill, was here representing the Stroke Advisory Council, of which he is a member. Dr. Wong stated that stroke care in NC is over one million dollars per day. Sen. Dr. Purcell asked Dr. Wong to educate the committee on

what to do if someone thinks they are having a stroke. Dr. Wong replied call 911, do not get into a car to drive yourself to the Emergency Room and do not take aspirin. Sen. Dr. Forrester asked for a favorable report. The motion being, unfavorable to the original bill, but favorable to the Proposed Committee Substitute with a sequential referral to Appropriation/Base Budget. Sen. Hagan wanted to comment that she felt the $300,000. for public awareness was good. Her mother actually had a massive stroke at the age of 51. She had high blood pressure and stopped taking her blood pressure medication. After the stroke she lived three and a half years disabled. Sen. Hagan pointed out that if her mother had stayed on her medication the stroke probably would not have happened. She stated this bill would help a lot of people. The vote was taken and SB 42 passed and will go to Appropriations.

Sen. Bingham recognized Sen. Dr. Purcell to present, SB 474, ***Reduce Perinatal Mortality and Disease.*** Sen. Dr. Purcell stated SB 474 appropriated $500,000. for the UNC School of Medicine at Chapel Hill, to support the Perinatal Quality Collaborative of NC. This is a network of providers, families, hospital administrators, health experts and payers committed to improving the clinical and health systems in perinatal care to reduce infant and maternal mortality and disease. In 2005, forty-eight percent of all child deaths in NC were the result of premature births, birth defects, and birth related conditions. Infant mortality in NC in 2005 was 8.8 per 1,000 live births. Dr. Dave Tayloe, Jr., NC Pediatric Society stated that forty-two percent of NC births were born to single parents. Sen. Kinnaird referenced Universal Health Care, stating we are the only Western Industrialized Country that does not have Universal Health Care and we have a high infant morality rate as a result. Senator Dannelly called for a favorable report. The bill had a sequential referral to appropriation. The motion carried.

Sen. Atwater wanted to comment on the first bill, SB 260, asking that any educational material provided to the parents to carry the appropriate cautionary information about any new vaccine.

The meeting adjourned at 11:50 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, March 15, 2007

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

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

S.B. **260** Schools Provide Info on Cervical Cancer.

Draft Number:	PCS35214
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

Monday, March 19, 2007

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

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

S.B. **42** Justus-Warren Task Force Recommendations.

Draft Number:	PCS 85049
Sequential Referral:	Appropriations/Base Budget
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

Wednesday, March 14, 2007

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

FAVORABLE

S.B. **474** Reduce Perinatal Mortality and Disease.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 260

Short Title:	Schools Provide Info on Cervical Cancer.	(Public)
Sponsors:	Senators Dorsett, Cowell; Albertson, Berger of Franklin, Bingham, Boseman, Clodfelter, Dannelly, Foriest, Garrou, Graham, Hagan, Jones, Kinnaird, Malone, Nesbitt, Preston, Purcell, Queen, Rand, Smith, Snow, Stevens, Tillman, and Weinstein.	
Referred to:	Health Care.	

February 22, 2007

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT EDUCATIONAL MATERIALS ARE PROVIDED SO THAT SCHOOLS PROVIDE INFORMATION TO PARENTS AND GUARDIANS CONCERNING CERVICAL CANCER, CERVICAL DYSPLASIA, HUMAN PAPILLOMAVIRUS, AND THE VACCINES AVAILABLE TO PREVENT THESE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"(49) To Ensure that Schools Provide Information Concerning Cervical Cancer, Cervical Dysplasia, Human Papillomavirus, and the Vaccines Available to Prevent These Diseases. – Local boards of education shall ensure that schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and places parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 2. G.S. 115C-238.29F(a) reads as rewritten:

"(a) Health and Safety Standards. – A charter school shall meet the same health and safety requirements required of a local school administrative unit. The Department of Public Instruction shall ensure that charter 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.

The Department of Public Instruction shall also ensure that charter schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five though 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 3. G.S. 115C-548 reads as rewritten:

"**§ 115C-548. Attendance; health and safety regulations.**

Each private church school or school of religious charter shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to these schools so that they can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to these schools so that they can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information may be provided electronically or on the Division's web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 4. G.S. 115C-556 reads as rewritten:

"**§ 115C-556. Attendance; health and safety regulations.**

Each qualified nonpublic school shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with

this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 5. G.S. 115C-565 reads as rewritten:

"**§ 115C-565. Requirements exclusive.**

No school which complies with this Part shall be subject to any other provision of law relating to education except requirements of law respecting immunization. The Division of Nonpublic Education, Department of Administration, shall provide to home schools information about meningococcal meningitis and influenza and their vaccines. This information may be provided electronically or on the Division's Web page. The 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.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 6. The Division of Public Health, Department of Health and Human Services, shall make available sample educational materials that can be

provided to parents and guardians. The Division shall provide these materials to (i) local school administrative units for public schools other than charter schools, (ii) the Department of Public Instruction for charter schools, and (iii) the Division of Nonpublic Education, Department of Administration, for nonpublic schools including home schools. These materials may be provided electronically.

SECTION 7. This act becomes effective July 1, 2007, and applies beginning with the 2007-2008 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 260
PROPOSED COMMITTEE SUBSTITUTE S260-CSRC-4 [v.1]

3/13/2007 3:21:50 PM

Short Title: Schools Provide Info on Cervical Cancer. (Public)

Sponsors:

Referred to:

February 22, 2007

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT EDUCATIONAL MATERIALS ARE PROVIDED SO THAT SCHOOLS PROVIDE INFORMATION TO PARENTS AND GUARDIANS CONCERNING CERVICAL CANCER, CERVICAL DYSPLASIA, HUMAN PAPILLOMAVIRUS, AND THE VACCINES AVAILABLE TO PREVENT THESE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"(49) To Ensure that Schools Provide Information Concerning Cervical Cancer, Cervical Dysplasia, Human Papillomavirus, and the Vaccines Available to Prevent These Diseases. – Local boards of education shall ensure that schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and places parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 2. G.S. 115C-238.29F(a) reads as rewritten:

"(a) Health and Safety Standards. – A charter school shall meet the same health and safety requirements required of a local school administrative unit. The Department of Public Instruction shall ensure that charter 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.

The Department of Public Instruction shall also ensure that charter schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five though 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 3. G.S. 115C-548 reads as rewritten:

"**§ 115C-548. Attendance; health and safety regulations.**

Each private church school or school of religious charter shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to these schools so that they can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to these schools so that they can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 4. G.S. 115C-556 reads as rewritten:

"**§ 115C-556. Attendance; health and safety regulations.**

Each qualified nonpublic school shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to

reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 5. G.S. 115C-565 reads as rewritten:

"**§ 115C-565. Requirements exclusive.**

No school which complies with this Part shall be subject to any other provision of law relating to education except requirements of law respecting immunization. The Division of Nonpublic Education, Department of Administration, shall provide to home schools information about meningococcal meningitis and influenza and their vaccines. This information may be provided electronically or on the Division's Web page. The 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.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their female children."

SECTION 6. The Division of Public Health, Department of Health and Human Services, shall make available sample educational materials that can be provided to parents and guardians. The Division shall provide these materials to (i) local school administrative units for public schools other than charter schools, (ii) the Department of Public Instruction for charter schools, and (iii) the Division of Nonpublic Education, Department of Administration, for nonpublic schools including home schools. These materials may be provided electronically.

SECTION 7. This act becomes effective July 1, 2007, and applies beginning with the 2007-2008 school year. However, during the 2007-2008 school year, year-round schools may comply with the provisions of this act by providing the required information no later than September 1, 2007.

SENATE BILL 260:
Schools Provide Info on Cervical Cancer

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 13, 2007
Introduced by:	Sen. Dorsett	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition S260-CSRC-4		Committee Counsel

SUMMARY: ***SB260 would require that information concerning cervical cancer, cervical dysplasia, human papillomavirus and the vaccines available to prevent those diseases be made available to public schools (including charter schools), private religious schools, qualified nonpublic schools and home schools. The information would have to be distributed to parents of children enrolled in public schools in grades five through 12 at the beginning of each school year.***

The Proposed Committee Substitute removes language requiring that the material be distributed to parents of children enrolled in private or home schools. This change is made because the State does not have the authority to require that these actions be taken.

CURRENT LAW: All schools in North Carolina (public, private and home) that teach children in grades kindergarten though 12 must maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Charter schools must meet all the same health and safety requirements of other public schools of the local school administrative unit.

The office of Nonpublic Education in the Department of Administration is charged with providing information to private schools and home schools regarding meningococcal meningitis and influenza and their vaccines. The information may be provided electronically. The information must include the diseases' causes and symptoms, how they are transmitted, how they may be prevented by vaccine, and places where parents may obtain vaccines for their children. Similar requirements exist for public schools and charter schools, although those schools are required to distribute the information at the beginning of each school year.

BILL ANALYSIS:

Section 1 requires local boards of education to ensure that schools provide parents and guardians with information regarding cervical cancer, cervical dysplasia, human papillomavirus and the vaccines available to prevent those disease. The information must be provided to parents of children entering grades 5-12 at the beginning of each school year. . The information must include the diseases' causes and symptoms, how they are transmitted, how they may be prevented by vaccine, and places where parents may obtain vaccines for their female children. The information may be provided electronically

Section 2 has language that is similar to Section 1, but it applies to charter schools.

Sections 3-5 have language that is similar to Section 1 and 2, but apply to private schools and home schools. However, these sections do not require the distribution of the information at the beginning of the school year because the State does not have the authority to make that requirement.

EFFECTIVE DATE: The act would become effective July 1, 2007. However, a year-round school may comply with the requirements during the 2007-2008 school year by distributing the information no later than September 1, 2007.

S0260e1-SMRC-CSRC-4

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____

S. B. No 260

COMMITTEE SUBSTITUTE ✓

DATE 3/14/07

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

Rep.)
Sen.) Nesbitt

moves to amend the bill on page 1, line 20

( ) WHICH CHANGES THE TITLE

by deleting the word "female";

and on page 2, line 10 by deleting the word "female";

and on page 2, line 36 by deleting the word "female";

and on page 3, line 18 by deleting the word "female";

and on page 3, line 36, by deleting the word "female"

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

HPV (HUMAN PAPILLOMAVIRUS) VACCINE

WHAT YOU NEED TO KNOW

1 What is HPV?

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States.

There are about 40 types of HPV. About 20 million people in the U.S. are infected, and about 6.2 million more get infected each year. HPV is spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV is important mainly because it can cause **cervical cancer** in women. Every year in the U.S. about 10,000 women get cervical cancer and 3,700 die from it. It is the 2nd leading cause of cancer deaths among women around the world.

HPV is also associated with several less common types of cancer in both men and women. It can also cause genital warts and warts in the upper respiratory tract.

More than 50% of sexually active men and women are infected with HPV at sometime in their lives.

There is no treatment for HPV infection, but the conditions it causes can be treated.

2 HPV Vaccine - Why get vaccinated?

HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV.

These include 2 types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. ***HPV vaccine can prevent most genital warts and most cases of cervical cancer.***

Protection from HPV vaccine is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

3 Who should get HPV vaccine and when?

Routine Vaccination

- HPV vaccine is routinely recommended for girls **11-12 years of age**. Doctors may give it to girls as young as 9 years. It is given as a 3-dose series:

1st Dose:	Now
2nd Dose:	2 months after Dose 1
3rd Dose:	6 months after Dose 1

Why is HPV vaccine given to girls at this age?

It is important for girls to get HPV vaccine **before** their first sexual contact – because they have not been exposed to HPV. For these girls, the vaccine can prevent almost 100% of disease caused by the 4 types of HPV targeted by the vaccine.

However, if a girl or woman is already infected with a type of HPV, the vaccine will not prevent disease from that type.

Catch-Up Vaccination

- The vaccine is also recommended for girls and women **13-26 years of age** who did not receive it when they were younger.

No booster doses are recommended at this time.

HPV vaccine may be given at the same time as other vaccines.

4 Some girls or women should not get HPV vaccine or should wait

- Anyone who has ever had a life-threatening **allergic reaction** to **yeast**, to **any other component of HPV vaccine**, or to a **previous dose of HPV vaccine** should not get the vaccine. Tell your doctor if the person getting the vaccine has any severe allergies.

- **Pregnant women** should not get the vaccine. The vaccine appears to be safe for both the mother and the unborn baby, but it is still being studied. Receiving HPV vaccine when pregnant is **not** a reason to consider terminating the pregnancy. Women who are breast feeding may safely get the vaccine.

> Any woman who learns that she was pregnant when she got HPV vaccine is encouraged to call the **HPV vaccine in pregnancy registry** at 800-986-8999.
>
> Information from this registry will help us learn how pregnant women respond to the vaccine.

- People who are mildly ill when the shot is scheduled can still get HPV vaccine. People with **moderate or severe illnesses** should wait until they recover.

5 What are the risks from HPV vaccine?

HPV vaccine does not appear to cause any serious side effects.

However, a vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of **any** vaccine causing serious harm, or death, is extremely small.

Several **mild problems** may occur with HPV vaccine:

- Pain at the injection site (about 8 people in 10)
- Redness or swelling at the injection site (about 1 person in 4)
- Mild fever (100°F) (about 1 person in 10)
- Itching at the injection site (about 1 person in 30)
- Moderate fever (102°F) (about 1 person in 65)

These symptoms do not last long and go away on their own.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Like all vaccines, HPV vaccine will continue to be monitored for unusual or severe problems.

6 What if there is a severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can show you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's website at **www.cdc.gov/std/hpv** and **www.cdc.gov/nip.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 260
PROPOSED COMMITTEE SUBSTITUTE S260-PCS35214-RC-4

Short Title: Schools Provide Info on Cervical Cancer. (Public)

Sponsors:

Referred to:

February 22, 2007

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT EDUCATIONAL MATERIALS ARE PROVIDED SO THAT SCHOOLS PROVIDE INFORMATION TO PARENTS AND GUARDIANS CONCERNING CERVICAL CANCER, CERVICAL DYSPLASIA, HUMAN PAPILLOMAVIRUS, AND THE VACCINES AVAILABLE TO PREVENT THESE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"(49) To Ensure that Schools Provide Information Concerning Cervical Cancer, Cervical Dysplasia, Human Papillomavirus, and the Vaccines Available to Prevent These Diseases. – Local boards of education shall ensure that schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and places parents and guardians may obtain additional information and vaccinations for their children."

SECTION 2. G.S. 115C-238.29F(a) reads as rewritten:

"(a) Health and Safety Standards. – A charter school shall meet the same health and safety requirements required of a local school administrative unit. The Department of Public Instruction shall ensure that charter 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.

The Department of Public Instruction shall also ensure that charter schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five though 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children."

SECTION 3. G.S. 115C-548 reads as rewritten:

"§ 115C-548. Attendance; health and safety regulations.

Each private church school or school of religious charter shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to these schools so that they can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to these schools so that they can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children."

SECTION 4. G.S. 115C-556 reads as rewritten:

"§ 115C-556. Attendance; health and safety regulations.

Each qualified nonpublic school shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to

reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children."

SECTION 5. G.S. 115C-565 reads as rewritten:

"**§ 115C-565. Requirements exclusive.**

No school which complies with this Part shall be subject to any other provision of law relating to education except requirements of law respecting immunization. The Division of Nonpublic Education, Department of Administration, shall provide to home schools information about meningococcal meningitis and influenza and their vaccines. This information may be provided electronically or on the Division's Web page. The 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.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children."

SECTION 6. The Division of Public Health, Department of Health and Human Services, shall make available sample educational materials that can be provided to parents and guardians. The Division shall provide these materials to (i) local school administrative units for public schools other than charter schools, (ii) the Department of Public Instruction for charter schools, and (iii) the Division of Nonpublic Education, Department of Administration, for nonpublic schools including home schools. These materials may be provided electronically.

SECTION 7. This act becomes effective July 1, 2007, and applies beginning with the 2007-2008 school year. However, during the 2007-2008 school year,

year-round schools may comply with the provisions of this act by providing the required information no later than September 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 42*

Short Title:	Justus-Warren Task Force Recommendations.	(Public)
Sponsors:	Senators Purcell; Atwater, Berger of Franklin, Cowell, Dannelly, Dorsett, Forrester, Garrou, Graham, Kinnaird, Malone, Nesbitt, Rand, and Swindell.	
Referred to:	Health Care.	

February 12, 2007

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO IMPLEMENT THE RECOMMENDATIONS OF THE STROKE ADVISORY COUNCIL OF THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

Whereas, the Stroke Advisory Council was established by the Justus-Warren Heart Disease and Stroke Prevention Task Force to advise the Task Force regarding the development of a statewide system of stroke care; and

Whereas, North Carolina is one of only four states funded by the Centers for Disease Control and Prevention (CDC) to operate a stroke registry within the Paul Coverdell National Stroke Registry initiative; and

Whereas, the North Carolina Collaborative Stroke Registry has received commendations from the CDC for stroke care performance measures and the sustained improvement in quality that has been achieved by participating NC registry hospitals; and

Whereas, monitoring care for stroke patients is an essential component of any system of care in this State; and

Whereas, timely and appropriate stroke treatment is essential to improving stroke patient outcomes; and

Whereas, it is critical to engage community groups in high need areas to assist in disseminating and reinforcing awareness messages and materials; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The General Assembly supports the recommendations of the Stroke Advisory Council, as approved by the Justus-Warren Heart Disease and Stroke Prevention Task Force. To this end, certain of the Stroke Advisory Council's

Preliminary Findings and Recommendations for a NC System of Stroke Care, January, 2007, shall be carried out as follows:

(1) The Justus-Warren Heart Disease and Stroke Prevention Task Force shall work with health care providers across the State to establish a system of regionally distributed and locally determined stroke care networks for the State.

(2) The Stroke Advisory Council shall include in its comprehensive plan for 2008 a process for identifying and disseminating information about Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certified primary stroke centers in order to assist in the configuration and operation of regional systems of stroke care.

SECTION 2.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of four hundred thousand dollars ($400,000) for the 2007-2008 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2008-2009 fiscal year. These funds shall be used to match existing federal funds for the NC Collaborative Stroke Registry to increase North Carolina hospital participation in the registry, particularly those hospitals in high stroke/low resource areas of the State.

SECTION 2.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of one hundred fifty thousand dollars ($150,000) for the 2007-2008 fiscal year and the sum of one hundred fifty thousand dollars ($150,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch to contract with Area Health Education Centers (AHEC) to work with the North Carolina Collaborative Stroke Registry to develop and carry out professional workforce development, training, and communications initiatives among hospitals, emergency medical services responders, 911 operators, and other stakeholders.

SECTION 2.(c) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of three hundred thousand dollars ($300,000) for the 2007-2008 fiscal year and the sum of three hundred thousand dollars ($300,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch for the development and implementation of public awareness campaigns and communication strategies on stroke signs and symptoms and the importance of immediate response.

SECTION 2.(d) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of ten thousand dollars ($10,000) for the 2007-2008 fiscal year and the sum of ten thousand dollars ($10,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch to conduct a follow-up survey and gap analysis designed to provide a current assessment of stroke prevention and treatment services in the State. The purpose of these funds is to assist in the development of a comprehensive stroke care system plan.

SECTION 2.(e) There is appropriated from the General Fund to the Justus-Warren Heart Disease and Stroke Prevention Task Force the sum of fifty

thousand dollars ($50,000) for the 2007-2008 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2008-2009 fiscal year. These funds shall be allocated for operations of the Stroke Advisory Council.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 42*
PROPOSED COMMITTEE SUBSTITUTE S42-PCS85049-LN-3

Short Title: Justus-Warren Task Force Recommendations. (Public)

Sponsors:

Referred to:

February 12, 2007

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO IMPLEMENT THE RECOMMENDATIONS OF THE STROKE ADVISORY COUNCIL OF THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

Whereas, the General Assembly directed the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish a Stroke Advisory Council to advise the Task Force regarding the development of a statewide system of stroke care; and

Whereas, monitoring the level and quality of care for stroke patients is an essential component of any system of care in this State; and

Whereas, several stroke care monitoring and quality improvement tools such as the American Heart Association's Get With the Guidelines – Stroke and the North Carolina Collaborative Stroke Registry are available to North Carolina hospitals; and

Whereas, employing either of these tools can help improve a hospital's level and quality of care for stroke patients; and

Whereas, North Carolina is one of only four states funded by the Centers for Disease Control and Prevention (CDC) to operate a stroke registry within the Paul Coverdell National Stroke Registry initiative; and

Whereas, the North Carolina Collaborative Stroke Registry has received commendations from the CDC for stroke care performance measures and the sustained improvement in quality that has been achieved by participating NC registry hospitals; and

Whereas, timely and appropriate stroke treatment is essential to improving stroke patient outcomes; and

Whereas, the NC Office of Emergency Medical Service (NCOEMS) Stroke Toolkit will enhance EMS capacity for timely and appropriate stroke care; and

Whereas, it is critical to engage community groups in high need areas to assist in disseminating and reinforcing awareness messages and materials; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The General Assembly supports the recommendations of the Stroke Advisory Council, as approved by the Justus-Warren Heart Disease and Stroke Prevention Task Force. To this end, certain of the Stroke Advisory Council's Preliminary Findings and Recommendations for a NC System of Stroke Care, January 2007, shall be carried out as follows:

(1) The Justus-Warren Heart Disease and Stroke Prevention Task Force shall work with health care providers across the State to establish a system of regionally distributed and locally determined stroke care networks for the State.

(2) The Stroke Advisory Council shall include in its comprehensive plan for 2008 a process for identifying and disseminating information about primary stroke centers certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other nationally recognized accrediting body in order to assist in the configuration and operation of regional systems of stroke care.

SECTION 2.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of four hundred thousand dollars ($400,000) for the 2007-2008 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2008-2009 fiscal year. These funds shall be used to match existing federal funds for the NC Collaborative Stroke Registry to increase North Carolina hospital participation in the registry, particularly those hospitals in high stroke/low resource areas of the State.

SECTION 2.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of one hundred fifty thousand dollars ($150,000) for the 2007-2008 fiscal year and the sum of one hundred fifty thousand dollars ($150,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch to contract with entities such as Area Health Education Centers (AHEC) and NCOEMS to work with the North Carolina Collaborative Stroke Registry and the American Stroke Association to carry out professional workforce development, training, and communications initiatives among hospitals, emergency medical services responders, 911 operators, and other stakeholders.

SECTION 2.(c) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of three hundred thousand dollars ($300,000) for the 2007-2008 fiscal year and the sum of three hundred thousand dollars ($300,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch for the implementation of public awareness campaigns and communication strategies in partnership with the American Stroke Association on stroke signs and symptoms and the importance of immediate response.

SECTION 2.(d) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of ten thousand dollars ($10,000) for the 2007-2008 fiscal year and the sum of ten thousand dollars ($10,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch in partnership with the American Stroke Association, the Carolinas Center for Medical Excellence, and the North Carolina Hospital Association to conduct a follow-up survey and gap analysis designed to provide a current assessment of stroke prevention and treatment services in the State. The purpose of these funds is to assist in the development of a comprehensive stroke care system plan.

SECTION 2.(e) There is appropriated from the General Fund to the Justus-Warren Heart Disease and Stroke Prevention Task Force the sum of fifty thousand dollars ($50,000) for the 2007-2008 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2008-2009 fiscal year. These funds shall be allocated for operations of the Stroke Advisory Council.

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

SENATE BILL 42:
Justus-Warren Task Force Recommendations

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 13, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker Legislative Analyst
Version:	PCS to First Edition S42-PCS85049-LN-3		

SUMMARY: ***Senate Bill 42 would appropriate $910,000 to implement recommendations of the Stroke Advisory Council of the Justus-Warren Heart Disease and Stroke Prevention Task Force.***

CURRENT LAW:

Session Law 2006-197 directed the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish and maintain a Stoke Advisory Council. The Council advises the Task Force regarding the development of a statewide system of stroke care.

BILL ANALYSIS:

Section 1 directs the Justus-Warren Heart Disease and Stroke Prevention Task Force to work with health care providers across the State to establish a system of stroke care networks. The section also directs the Stroke Advisory Council to include in its 2008 plan, a process for identifying and disseminating information about certified or accredited primary stroke centers.

Section 2 appropriates from the General Fund to the Department of Health and Human Services, Division of Public Health for the **2007-08** fiscal year and the **2008-09** fiscal year:

- Four hundred thousand dollars ($400,000) to match existing federal funds to increase hospital participation in the NC Collaborative Stroke Registry;
- One hundred fifty thousand dollars ($150,000) to be allocated to the Heart Disease and Stroke Prevention Branch to contract with other entities to carry out professional workforce development, training, and communication initiatives with relevant stakeholders;
- Three hundred thousand dollars ($300,000) to be allocated to the Heart Disease and Stroke Prevention Branch for the implementation of public awareness campaigns including those in partnership with the American Stroke Association.
- Ten thousand dollars ($10,000) to be allocated to the Heart Disease and Stroke Prevention Branch, in partnership with the American Stroke Association, the Carolinas Center for Medical Excellence and the North Carolina Hospital Association to conduct a follow-up survey and gap analysis that would provide a current assessment of stroke prevention and treatment services in the State.

The section further appropriates fifty thousand dollars ($50,000) for FY 2007-08 and FY 2008-09 to the Justus-Warren Heart Disease and Stroke Prevention Task Force for the operation of the Stroke Advisory Council.

Section 3 makes the appropriation provisions effective July 1, 2007. The remainder of the act is effective when it becomes law.

S0042e1-SMSQ-PCS85049-LN-3

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 42*
PROPOSED COMMITTEE SUBSTITUTE S42-PCS85049-LN-3

Short Title: Justus-Warren Task Force Recommendations. (Public)

Sponsors:

Referred to:

February 12, 2007

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO IMPLEMENT THE RECOMMENDATIONS OF THE STROKE ADVISORY COUNCIL OF THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

Whereas, the General Assembly directed the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish a Stroke Advisory Council to advise the Task Force regarding the development of a statewide system of stroke care; and

Whereas, monitoring the level and quality of care for stroke patients is an essential component of any system of care in this State; and

Whereas, several stroke care monitoring and quality improvement tools such as the American Heart Association's Get With the Guidelines – Stroke and the North Carolina Collaborative Stroke Registry are available to North Carolina hospitals; and

Whereas, employing either of these tools can help improve a hospital's level and quality of care for stroke patients; and

Whereas, North Carolina is one of only four states funded by the Centers for Disease Control and Prevention (CDC) to operate a stroke registry within the Paul Coverdell National Stroke Registry initiative; and

Whereas, the North Carolina Collaborative Stroke Registry has received commendations from the CDC for stroke care performance measures and the sustained improvement in quality that has been achieved by participating NC registry hospitals; and

Whereas, timely and appropriate stroke treatment is essential to improving stroke patient outcomes; and

Whereas, the NC Office of Emergency Medical Service (NCOEMS) Stroke Toolkit will enhance EMS capacity for timely and appropriate stroke care; and

Whereas, it is critical to engage community groups in high need areas to assist in disseminating and reinforcing awareness messages and materials; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The General Assembly supports the recommendations of the Stroke Advisory Council, as approved by the Justus-Warren Heart Disease and Stroke Prevention Task Force. To this end, certain of the Stroke Advisory Council's Preliminary Findings and Recommendations for a NC System of Stroke Care, January 2007, shall be carried out as follows:

(1) The Justus-Warren Heart Disease and Stroke Prevention Task Force shall work with health care providers across the State to establish a system of regionally distributed and locally determined stroke care networks for the State.

(2) The Stroke Advisory Council shall include in its comprehensive plan for 2008 a process for identifying and disseminating information about primary stroke centers certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other nationally recognized accrediting body in order to assist in the configuration and operation of regional systems of stroke care.

SECTION 2.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of four hundred thousand dollars ($400,000) for the 2007-2008 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2008-2009 fiscal year. These funds shall be used to match existing federal funds for the NC Collaborative Stroke Registry to increase North Carolina hospital participation in the registry, particularly those hospitals in high stroke/low resource areas of the State.

SECTION 2.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of one hundred fifty thousand dollars ($150,000) for the 2007-2008 fiscal year and the sum of one hundred fifty thousand dollars ($150,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch to contract with entities such as Area Health Education Centers (AHEC) and NCOEMS to work with the North Carolina Collaborative Stroke Registry and the American Stroke Association to carry out professional workforce development, training, and communications initiatives among hospitals, emergency medical services responders, 911 operators, and other stakeholders.

SECTION 2.(c) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of three hundred thousand dollars ($300,000) for the 2007-2008 fiscal year and the sum of three hundred thousand dollars ($300,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch for the implementation of public awareness campaigns and communication strategies in partnership with the American Stroke Association on stroke signs and symptoms and the importance of immediate response.

SECTION 2.(d) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of ten thousand dollars ($10,000) for the 2007-2008 fiscal year and the sum of ten thousand dollars ($10,000) for the 2008-2009 fiscal year. These funds shall be allocated to the Heart Disease and Stroke Prevention Branch in partnership with the American Stroke Association, the Carolinas Center for Medical Excellence, and the North Carolina Hospital Association to conduct a follow-up survey and gap analysis designed to provide a current assessment of stroke prevention and treatment services in the State. The purpose of these funds is to assist in the development of a comprehensive stroke care system plan.

SECTION 2.(e) There is appropriated from the General Fund to the Justus-Warren Heart Disease and Stroke Prevention Task Force the sum of fifty thousand dollars ($50,000) for the 2007-2008 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2008-2009 fiscal year. These funds shall be allocated for operations of the Stroke Advisory Council.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 474

Short Title:	Reduce Perinatal Mortality and Disease.	(Public)
Sponsors:	Senators Purcell; Albertson, Atwater, Berger of Franklin, Bingham, Dannelly, Dorsett, Foriest, Hartsell, and Malone.	
Referred to:	Health Care.	

March 5, 2007

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE BOARD OF GOVERNORS OF THE UNIVERSITY OF NORTH CAROLINA TO SUPPORT THE PERINATAL QUALITY COLLABORATIVE OF NORTH CAROLINA, AS RECOMMENDED BY THE NORTH CAROLINA PEDIATRIC SOCIETY.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Board of Governors of The University of North Carolina the sum of five hundred thousand dollars ($500,000) for the 2007-2008 fiscal year and the sum of five hundred thousand dollars ($500,000) for the 2008-2009 fiscal year. These funds shall be allocated to the University of North Carolina at Chapel Hill School of Medicine to support the Perinatal Quality Collaborative of North Carolina (PQCNC). PQCNC is a network of stakeholders (providers, families, hospital administrators, health experts, and payers) committed to improving clinical and health systems issues in perinatal care. The purpose of PQCNC is to use a refined neonatal data set linked to other State databases and expert input from all stakeholders to implement quality improvement initiatives, which will reduce perinatal disease burden, optimize use of State medical funds, and meet the needs of North Carolina families as they receive perinatal care.

SECTION 2. This act becomes effective July 1, 2007.

SENATE BILL 474:
Reduce Perinatal Mortality and Disease

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 14, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 474 would authorize the appropriation of $500,000 from the General Fund each year for fiscal years 2007-2008 and 2008-2009 to support the Perinatal Quality Collaborative of North Carolina (PQCNC).

BILL ANALYSIS: Senate Bill 474 would authorize the appropriation of $500,000 from the General Fund each year for fiscal years 2007-2008 and 2008-2009 to support the Perinatal Quality Collaborative of North Carolina (PQCNC). Funds would be appropriated to the Board of Governors of the University of North Carolina for allocation to the University of North Carolina School of Medicine to support the PQCNC.

EFFECTIVE DATE: This act becomes effective July 1, 2007.

BACKGROUND: The PQCNC is a statewide network of perinatal providers, hospital administrators, government officials, health care payers and families whose mission is to execute quality improvement initiatives. The goal of these initiatives is to promote perinatal care practices that minimize the burden of diseases of mothers and infants in an economical and family-centered manner.

Specific aims of the PQCNC are:

- As an enabling and essential first step, develop and maintain **a statewide database** that includes information describing the characteristics, medical care and outcome of infants admitted to neonatal intensive care centers (NICC) in North Carolina.
- Using this database as the source of information, identify critical outcomes among NICC patients and conduct **quality improvement initiatives** with the goal of reducing variability of practice among centers and improving these outcomes.
- Using supplementary data from a variety of sources, monitor the **consumption of health care resources** and conduct initiatives with the goal of reducing resource consumption while maintaining quality of care.
- In collaboration with families, develop and implement strategies for the **integration of families** into care in NICCs.
- Develop strategies for the **evolution of the PQCNC in the area of perinatal/obstetrical care**.

With the support of the Perinatal Health Committee of the North Carolina Child Fatality Task Force, a legislative request was made to the 2006 General Assembly. In response, the Legislature designated $75,000 for the planning of the PQCNC and selected UNC to provide leadership for this effort. The deliverables for this legislation included: convening stakeholders statewide and creating a blue print for action. This funding from the state legislature indicated support and keen interest at the State level in improving perinatal health by focusing on quality improvement activities.

S0474e1-SMRD

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris Hollis	BCBS
Bill Scoggin	KCCH
Marlene Foster	Pfizer
Jenny Kaplan	MWC
Cliff Vanik	[illegible]
Bessie Carrington	LWV-ODC
Kristen Shepherd	NC Medical Soc.
Selena Berrier	Child Fatality Task Force
Patti Barron	CPM
Janelle Gay	League of Women Voters
Patty Madigan	L. of W. V.

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judi Lilley	LWV
Meg McElwain	LWV Charlotte
Jean Allen	LWV
Kay Hunt	LWV - ODC
JAN RICHARDS	LWV - ODC
Beverly Kawalec	LWV - ODC
Abby Bell	AHA/ASA
Kathy H. Check	AHA/ASA
Yvonne Schmidt	LWV - ODC
Brenda B. Shannon	LWV - ODC
Chuck Bolotin	LWV - ODC

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dorothy M. Turner	LWV ODC
Carri Sherrod	LWV ODC
John Thompson	ACS
Carol Rist	LWV ODC
Andrea G. Silva	self - 103 Dartmouth Dr Cary
Paula L. Hoel	League of Women Voters
Beverly Hamrick	" " ODC
Judie Hench	LWV NC
Karen Rindt	LWV NC
Tam Ngo	Senator Hagan
Elizabeth (Libby) Puckett	Heart Disease & Stroke Prevention

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
A. E. White	HDSP/DPH
Sylvia Coleman	HDSP/DPH, NC Collaborative Stroke Registry
Mary Klenz	League of Women Voters
Charles H. Wilson	Triangle Orthopaedic Associates, PA.
Rita Satterfield	Triangle Orthopaedic Associates, PA.
Chip Hedrick MPAS PAC	Triangle Orthopaedic Assoc. PA
Scott Gibson	Goldsboro Orthopaedic Assoc.
DAVID Rockwell	Goldsboro orthopaedic Assoc.
DAVID BOONE, MD	RALEIGH ORTHOPAEDIC CLINIC
ROBERT SCHULTZ, MD	DUKE UNIV. MED. CENTER
Jolene Spencer, RN	Beaufort County Hospital

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris DeRienzo	Duke Univ. School of Medicine
LyTonya Fowler	UNC-Chapel Hill
Holly Hernandez	UNC-Chapel Hill
GLBY KATUMKEERYIL	UNC CHAPEL HILL
Susan Hamer	WCPSS
Steve Shaw	NC Pediatric Society
Dave Taylor, Jr. MD	Goldsboro Pediatrics, PA
Suzanna E. Martin	Duke Pediatrics
Sarah Langer	NC DPI
Beth Rowe-West	DPH - NC DHHS (WCH)
Kevin Ryan	WCH, DPH - NC DHHS

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nancy Mueller	League of Women Voters - ODC
Judy McConnell	Daily Bulletin - ODC
Phyllis West	DPI
Rita L. Joyner	SBE
Anita Holmes	Justus-Warren Task Force DHHS
David Kalbacker	N.C. Board of Nursing
Barbara West	NCRL
Annie Butzen	Carolinas Center for Medical Excellence
David Huang	Dept of Neurology, UNC-CH
Chuck Stone	NCAHC/SEANC
Chris Rhyne	Civitas
Jeff Mixon Calendar White	civitas Gov. off.

VISITOR REGISTRATION SHEET

Senate Health Care — **March 14, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jimmy Jones	(Hinnicy - Raleigh)
John Rust	NCFPC
Joyce Rivera	[illegible]
Amy McConkey	S. A.
Susan Vaccaro	Nationwide
DAVID BARNES	Poyner + Spruill
Steve Mitchell	Novartis
John Bowdish	Astra Zeneca
Lee-Ann Chrisman	NCPA
Steve Keene	NC Medical Society
Lisa Piercy	NC Dental Society

VISITOR REGISTRATION SHEET

Senate Health Care — March 14, 2007

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Colleen Kochanek	NCCEP

Senate Health Care Committee
Wednesday, March 21, 2007, 11:00 AM
544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 448	Study/Brunswick County.	Senator Soles, Jr.
SB 666	Expand NC Institute of Medicine Membership.	Senator Garrou
HB 123	Emergency Dept. Data Sharing.-AB	Representative England, M.D. Representative Martin Representative Alexander Representative Glazier
HB 124	DENR's Embargo Authority for Food or Drink.-AB	Representative Martin Representative Glazier
HB 61	Child Restraint Systems/Federal Compliance.	Representative Folwell Representative Weiss Representative Goodwin Representative Glazier

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, March 21, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, March 21, 2007, in Room 544 of the Legislative Office Building, with fourteen members present, and Senator William R. Purcell presiding. Senator Purcell and Senator Stan Bingham, Co-Chairs, welcomed the committee members present, recognized the new members, and introduced the pages and sergeants-at-arms.

Senator Purcell recognized Representative Glazier to present his bill, HB 123 *Emergency Dept. Data Sharing.-AB*. Senator Berger moved for a favorable report.

Representative Glazier also presented HB124, *DENR/s Embargo Authority for Food or Drink.-AB*. Senator Bingham moved for a favorable report.

Representative Weiss was called on to present HB 61, *Child Restraint Systems/Federal Compliance*. Senator Berger voiced concern that the federal government could interfere with North Carolina law by withholding federal funds. Rep. Weiss agreed, but said that the only way to receive the funds ($1M) the state is entitled to is by passing this amendment. Senator Jones expressed concern that taxis do not have child safety seats. Senator Atwater said that law enforcement people should be made aware of any exception, and Rep. Weiss agreed, that this could be done through the Governor's Highway Safety Program. Senator Blake asked where the $1M would go. Rep. Weiss said that this money will go the Governor's Highway Safety Program and will be distributed through grants such as the one subsidizing child safety seats for low income families. Mr. Darryl Jernigan commented, reinforcing the need for this amendment, and outlining the few exceptions to this law. Senator Atwater moved for a favorable report.

Senator Soles spoke on his bill, SB 448, *Study Brunswick County*. A proposed committee substitute was adopted. Senator Purcell called on Mr. Dennis Streets of the Division of Aging, who made comments on the growing aging population in North Carolina. Mr. Ben Popkin, Research staff, was requested to explain the difference between the original bill and the proposed committee substitute. Senator Dannelly moved for a favorable report for the proposed committee substitute.

Senator Garrou spoke to her bill, SB 666, *Expand NC Institute of Medicine Membership*. An amendment to change to effective date of this bill was proposed and accepted, and will be rolled into a proposed committee substitute. Senator Hoyle moved for a favorable report for the amended bill.

The meeting adjourned at 1:50 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 Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, March 15, 2007

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

FAVORABLE

H.B. **61** Child Restraint Systems/Federal Compliance.
Sequential Referral: None
Recommended Referral: None

H.B. **123** Emergency Dept. Data Sharing.-AB
Sequential Referral: None
Recommended Referral: None

H.B. **124** DENR's Embargo Authority for Food or Drink.-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, March 22, 2007

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

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

S.B. **448** Study/Brunswick County.

Draft Number:	553888
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **666** Expand NC Institute of Medicine Membership.

Draft Number:	35340
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

HOUSE BILL 61

Short Title:	Child Restraint Systems/Federal Compliance.	(Public)
Sponsors:	Representatives Weiss, Goodwin, Glazier, Folwell (Primary Sponsors); Alexander, Carney, Faison, Fisher, Frye, Gillespie, Gulley, Hurley, Luebke, Martin, Neumann, Pate, Tillis, Underhill, and Wainwright.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 5, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CHILD RESTRAINT LAW TO ENSURE COMPLIANCE WITH FEDERAL REGULATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-137.1 reads as rewritten:

"**§ 20-137.1. Child restraint systems required.**

(a) Every driver who is transporting one or more passengers of less than 16 years of age shall have all such passengers properly secured in a child passenger restraint system or seat belt which meets federal standards applicable at the time of its manufacture.

(a1) A child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than eight years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

(b) The provisions of this section shall not apply: (i) to ambulances or other emergency vehicles; ~~(ii) when the child's personal needs are being attended to; (iii)~~(ii) if all seating positions equipped with child passenger restraint systems or seat belts are occupied; or ~~(iv)~~(iii) to vehicles which are not required by federal law or regulation to be equipped with seat belts.

(c) Any driver found responsible for a violation of this section may be punished by a penalty not to exceed twenty-five dollars ($25.00), even when more than one child less than 16 years of age was not properly secured in a restraint system. No driver

charged under this section for failure to have a child under eight years of age properly secured in a restraint system shall be convicted if he produces at the time of his trial proof satisfactory to the court that he has subsequently acquired an approved child passenger restraint system for a vehicle in which the child is normally transported.

(d) A violation of this section shall have all of the following consequences:

(1) Two drivers license points shall be assessed pursuant to G.S. 20-16.

(2) No insurance points shall be assessed.

(3) The violation shall not constitute negligence per se or contributory negligence per se.

(4) The violation shall not be evidence of negligence or contributory negligence."

SECTION 2. This act becomes effective June 1, 2007, and applies to offenses committed on or after that date.

HOUSE BILL 61:
Child Restraint Systems/Federal Compliance

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 20, 2007
Introduced by:	Reps. Weiss, Goodwin, Glazier, Folwell	**Summary by:**	Ben Popkin Committee Counsel
Version:	First Edition		

SUMMARY: ***House Bill 61 would amend the child restraint systems statute by removing an exception that allows a child to be out of a child passenger restraint system or seat belt when the child's personal needs are being attended to.***

[As introduced, this bill was identical to S23, as introduced by Sen. Purcell, which is currently in Senate Health Care.]

CURRENT LAW: G.S. 20-137.1 "Child restraint systems required" requires children younger than eight years of age and weighing less than eighty pounds to be properly secured in a weight-appropriate child passenger restraint system. If there is no seating position available that has a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system, a child younger than eight years of age and weighing between forty and eighty pounds may be restrained by a properly fitted lap belt alone. Subsection (b) of the statute makes exceptions from the child restraint system requirements for the following situations:

- Ambulances and other emergency vehicles;
- When the child's personal needs are being attended to;
- If all seating positions equipped with child passenger restraint systems or seat belts are occupied; and
- Vehicles which are not required by federal law or regulation to be equipped with seat belts.

Any driver found to have violated the provisions of G.S. 20-137.1 may be punished by a penalty not to exceed $25.00.

BILL ANALYSIS: House Bill 61 would remove the exception that a child younger than eight years old and weighing less than eighty pounds may be out of a child passenger restraint or seat belt if the child's needs are being attended to (second bulleted exception, above).

EFFECTIVE DATE: The bill would become effective June 1, 2007 and would apply to offenses committed on or after that date.

BACKGROUND: Under Section 2011 of the federal Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (Pub. L. 109-59), states can qualify for federal child safety and child booster seat incentive grants. In August 2006, the National Highway Traffic Safety Administration (NHTSA) determined that the provisions of G.S. 20-137.1 did not comply with the requirements of Section 2011 because of the exception that allows a child to ride unrestrained when the child's personal needs are being attending to. The NHTSA has stated that North Carolina would qualify for the aforementioned federal incentive grants if this exception were removed from G.S. 20-137.1.

Drupti Chauhan, counsel to House Judiciary II, substantially contributed to this summary.

H0061e1-SMRD

FEDERAL REQUIREMENT CERTIFICATION

Authorized by G.S. 120-36.8

Session 2007

House Bill 61

Child Restraint Systems/Federal Compliance

Bill Primary Sponsor(s):	Reps. Weiss, Goodwin, Glazier, Folwell	House Bill 61 1st Edition
Relevant Federal Law:	*Section 2011 of the Safe, Accountable, Flexible, Efficient Transporation Equity Act: A Legacy for Users, Pub. L.109-59*	
☒ Required by or Necessary for Compliance with Federal Law		☐ Exceeds Federal Law
☒ Federal Funds Conditioned upon Passage of Law		☐ Implements Federal Law

PRELIMINARY

SUMMARY OF BILL PROVISIONS ALLEGEDLY REQUIRED BY FEDERAL LEGISLATION

G.S. 20-137.1 currently requires children less than 8 years of age and less than 80 pounds to be property secured in a weight-appropriate child passenger restraint system. If there is no seating position available that has a lap and should belt to properly secure the weight-appropriate child passenger restraint system, a child less than 8 years of age and between 40-80 pounds may be restrained by a properly fitted lap belt alone. The statute makes exceptions from the child restraint system requirements for the following situations:

- Ambulances and other emergency vehicles;
- When the child's personal needs are being attended to;
- If all seating positions equipped with child passenger restraint systems or seat belts are occupied; or
- Vehicles which are not required by federal law to be equipped with seat belts

Any driver found to violate the statute may be punished by a penalty not to exceed $25.00.

House Bill 61 would remove the exception that a child less than 8 years and 80 pounds can be out of a child passenger restraint or seat belt if the child's needs are being attended to.

COMPLIANCE CONSIDERATIONS

Under Section 2011 of the federal Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users, Pub. L. 109-59, states can qualify for federal child safety and child booster seat incentive grants. In August, 2006, The National Highway Traffic Safety Administration (NHTSA) determined that G.S. 20-137.1 did not comply with Section 2011 because of the exception that allows a child to ride unrestrained when the child's personal needs are being attended to. The NHTSA has stated through a memorandum from John Donaldson, Assistant Chief Counsel for Legislation and General Law, NHTSA, U.S. Dept. of Transportation, to Marlene Markison, Assoc. Admin. for

Regional Operations and Program Delivery (January 10, 2007) that North Carolina would qualify if this exception were to be removed.

TECHNICAL OR MECHANICAL CONSIDERATIONS

REVIEW AND APPROVAL

Prepared By: Drupti Chauhan — **Date:** 3/12/07

Drupti Chauhan
Title of Preparer

Approved By: Terrence D. Sullivan — **Date:** 3/12/07

Terrence D. Sullivan
Director of Research

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE DRS35037-MA-54A (1/25)

Short Title:	Child Restraint Systems/Federal Compliance.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CHILD RESTRAINT LAW TO ENSURE COMPLIANCE WITH FEDERAL REGULATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-137.1 reads as rewritten:

"**§ 20-137.1. Child restraint systems required.**

(a) Every driver who is transporting one or more passengers of less than 16 years of age shall have all such passengers properly secured in a child passenger restraint system or seat belt which meets federal standards applicable at the time of its manufacture.

(a1) A child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than eight years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

(b) The provisions of this section shall not apply: (i) to ambulances or other emergency vehicles; ~~(ii) when the child's personal needs are being attended to; (iii)~~(ii) if all seating positions equipped with child passenger restraint systems or seat belts are occupied; or ~~(iv)~~(iii) to vehicles which are not required by federal law or regulation to be equipped with seat belts.

(c) Any driver found responsible for a violation of this section may be punished by a penalty not to exceed twenty-five dollars ($25.00), even when more than one child less than 16 years of age was not properly secured in a restraint system. No driver

charged under this section for failure to have a child under eight years of age properly secured in a restraint system shall be convicted if he produces at the time of his trial proof satisfactory to the court that he has subsequently acquired an approved child passenger restraint system for a vehicle in which the child is normally transported.

(d) A violation of this section shall have all of the following consequences:

(1) Two drivers license points shall be assessed pursuant to G.S. 20-16.

(2) No insurance points shall be assessed.

(3) The violation shall not constitute negligence per se or contributory negligence per se.

(4) The violation shall not be evidence of negligence or contributory negligence."

SECTION 2. This act becomes effective June 1, 2007, and applies to offenses committed on or after that date.

HOUSE BILL 123

Short Title:	Emergency Dept. Data Sharing.-AB	(Public)
Sponsors:	Representatives Glazier, Martin, Alexander, England (Primary Sponsors); Adams, Coleman, Farmer-Butterfield, Harrison, Mobley, and Wainwright.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE STATE HEALTH DIRECTOR TO SHARE EMERGENCY DEPARTMENT DATA WITH THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) FOR PUBLIC HEALTH PURPOSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-480 reads as rewritten:

"**§ 130A-480. Emergency department data reporting.**

(a) For the purpose of ensuring the protection of the public health, the State Health Director shall develop a syndromic surveillance program for hospital emergency departments in order to detect and investigate public health threats that may result from (i) a terrorist incident using nuclear, biological, or chemical agents or (ii) an epidemic or infectious, communicable, or other disease. The State Health Director shall specify the data to be reported by hospitals pursuant to this program, subject to the following:

(1) Each hospital shall submit electronically available emergency department data as specified by rule by the Commission. The Commission, in consultation with hospitals, shall establish by rule a schedule for the implementation of full electronic reporting capability of all data elements by all hospitals. The schedule shall take into consideration the number of data elements already reported by the hospital, the hospital's capacity to electronically maintain the remaining elements, available funding, and other relevant factors.

(2) None of the following data for patients or their relatives, employers, or household members may be collected by the State Health Director: names; postal or street address information, other than town or city, county, state, and the first five digits of the zip code; geocode information; telephone numbers; fax numbers; electronic mail addresses; social security numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; vehicle identifiers

and serial numbers, including license plate numbers; device identifiers and serial numbers; web universal resource locators (URLs); Internet protocol (IP) address numbers; biometric identifiers, including finger and voice prints; and full face photographic images and any comparable images.

(b) The following are not public records under Chapter 132 of the General Statutes and are privileged and confidential:

(1) Data reported to the State Health Director pursuant to this section.

(2) Data collected or maintained by any entity with whom the State Health Director contracts for the reporting, collection, or analysis of data pursuant to this section.

The State Health Director shall maintain the confidentiality of the data reported pursuant to this section and shall ensure that adequate measures are taken to provide system security for all data and information. The State Health Director may share data with local health departments and the Centers for Disease Control and Prevention (CDC) for public health ~~purposes, and the local~~ purposes. Local health departments are bound by the confidentiality provisions of this section. The Department shall enter into an agreement with the CDC to ensure that the CDC complies with the confidentiality provisions of this section. The State Health Director shall not allow information that it receives pursuant to this section to be used for commercial purposes and shall not release data except as authorized by other provisions of law.

(c) A person is immune from liability for actions arising from the required submission of data under this Article.

(d) For purposes of this section, "hospital" means a hospital, as defined in G.S. 131E-214.1(3), that operates an emergency room on a 24-hour basis. The term does not include a psychiatric hospital that operates an emergency room.

(e) Administrative emergency department data shall be reported by hospitals under Article 11A of Chapter 131E of the General Statutes."

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

HOUSE BILL 123:
Emergency Dept. Data Sharing.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 20, 2007
Introduced by:	Reps. Glazier, Martin, Alexander, England	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Co-Counsel

SUMMARY: House Bill 123 is an agency bill requested by the Department of Health and Human Services. It would allow the State Health Director to share hospital emergency department data with the Centers for Disease Control and Prevention (CDC). The bill is effective when it becomes law.

CURRENT LAW: G.S. 130A-480 directs the State Health Director to develop a syndromic surveillance program for hospital emergency departments in order to detect and investigate public health threats that may result from (i) a terrorist incident using nuclear, biological or chemical agents or (ii) an epidemic or infectious, communicable, or other disease. The data that is collected is not a public record and is privileged and confidential. However, the State Health Director may share the data with local health departments which are also bound by the confidentiality requirements of the statute.

The following is the information that is collected:

(1) Patient record number or other unique identification number;
(2) Patient date of birth and age;
(3) Patient's sex;
(4) City of residence;
(5) County of residence;
(6) Five digit ZIP code;
(7) Alpha numeric patient control number assigned by the hospital for each record (the Visit Identification Number);
(8) Emergency department facility identification number;
(9) Projected payor source;
(10) Date and time of emergency department visit (first documented time);
(11) Mode of transport to the emergency department;
(12) PreMIS identification number, if transported by EMS;
(13) Chief complaint;
(14) Initial temperature reading and route;
(15) Initial systolic and initial diastolic blood pressure;
(16) Triage Notes (brief description of patient's/family's self-reported illness episode, including symptoms, duration of symptoms, and reasons for visit [in addition to Chief Complaint] as presented by the patient or family to the triage nurse upon arrival at the emergency department) – this element is optional;
(17) Initial emergency department acuity assessment;
(18) Coded cause of injury (ICD-9-CM, if injury related to diagnosis);
(19) Emergency department procedures, up to ten (CPT or ICD-9-CM or ICD-10-CM);
(20) Emergency department disposition;
(21) Emergency department disposition diagnosis description; and
(22) Emergency department disposition diagnosis codes, one primary and up to ten additional (ICD-9-CM or ICD-10-CM).

H0123e1-SMRD

Kory Goldsmith, counsel to House Health, substantially contributed to this summary.

HOUSE BILL 124

Short Title:	DENR's Embargo Authority for Food or Drink.-AB	(Public)
Sponsors:	Representatives Glazier, Martin (Primary Sponsors); Adams, Coleman, Farmer-Butterfield, Harrison, Mobley, and Wainwright.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE EMBARGO AUTHORITY OF THE SECRETARY OF ENVIRONMENT AND NATURAL RESOURCES AND LOCAL HEALTH DIRECTORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-21(a) reads as rewritten:

"(a) In addition to the authority of the Department of Agriculture and Consumer Services pursuant to G.S. 106-125, the Secretary of Environment and Natural Resources 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 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~~ Chapter, that is subject to rules adopted by the Commission, 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,~~the Director of the Division of Environmental Health or the Director's designee, in programs regulating food and drink pursuant to this ~~Chapter.~~Chapter or in programs regulating food and drink that are subject to rules adopted by the Commission. 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~~ specialist, the Director of the Division of Environmental Health or the Director's designee, the local health director, 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."

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

HOUSE BILL 124:
DENR's Embargo Authority for Food or Drink.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 20, 2007
Introduced by:	Reps. Glazier, Martin	**Summary by:**	Kory Goldsmith
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 124 amends the law to include day care centers and county jails among the establishments that are subject to the Department of Environment and Natural Resource's (DENR) embargo authority for contaminated or adulterated food and drink. It also adds local health directors to the group of officials authorized to prohibit the removal or sale of food or drink that is subject to an embargo action.***

The act is effective when it becomes law.

CURRENT LAW: Prior to 2006, only the Department of Agriculture and Consumer Services (Agriculture) had the authority to detain or embargo a food product because the product was adulterated or so misbranded as to be dangerous or fraudulent. G.S. 106-125. The Commission of Agriculture could delegate the embargo authority to either the Secretary of DENR (Secretary) or to local health directors.

Last session, the General Assembly granted independent embargo authority to the Secretary and to local health directors for food or drink in an establishment subject to regulation by the DENR under Chapter 130A of the General Statutes. S.L. 2006-80.

BILL ANALYSIS: The act allows the Secretary and local health directors to exercise embargo authority over food and drink establishments that are subject to rules adopted by the Commission for Health Services (Commission). These additional establishments are child care facilities and county jails. These establishments are not covered under the existing law because the Commission's regulatory authority for these entities is not contained in Chapter 130A of the General Statutes.

The act clarifies that the Director of the Division of Environmental Health or the Director's designee would have action authority to authorize an embargo action.

The act also adds local health directors to the officials who may authorize the removal or disposal of embargoed materials.

EFFECTIVE DATE: The act is effective when it becomes law.

Hal Pell, counsel to House Homeland Security, Military and Veterans Affairs, substantially contributed to this summary.

H0124e1-SMRC

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 448

Short Title:	Study/Brunswick County.	(Public)
Sponsors:	Senator Soles.	
Referred to:	Health Care.	

March 5, 2007

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONDUCT A STUDY TO IDENTIFY THE NEEDS OF THE AGING POPULATION IN BRUNSWICK AND OTHER COUNTIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Aging and Adult Services, shall conduct a study of the aging population in Brunswick and other counties that are experiencing or are projected to experience significant increases in the county's aging population. In conducting the study, the Division shall quantify the county's aging population, project future population growth, identify specific needs, and list services and agencies that are and will be required to meet these needs in the future. The study shall also recommend ways in which these services can be provided, costs associated with the services, and available funding sources. The Division shall report its findings and recommendations not later than May 1, 2008, to the 2008 Regular Session of the 2007 General Assembly and to the board of county commissioners of each county studied.

SECTION 2. This act becomes effective July 1, 2007.

SENATE BILL 448:
Study/Brunswick County

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 20, 2007
Introduced by:	Sen. Soles	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S448-CSSQ-6		Legislative Analyst

SUMMARY: ***Senate Bill 448 would direct the Department of Health and Human Services, Division of Aging and Adult Services, to study program and service needs for counties that anticipate significant growth in number of persons aged 65 years and older.***

BILL ANALYSIS:

Senate Bill 448 directs the Department of Health and Human Services, Division of Aging and Adult Services to conduct a study of counties projected to experience significant increases to the counties' older adult populations and determine the impact on programs and services that serve those populations.

The bill directs the study to address the following issues:

- Identify programs currently in place
- Identify programs needed to serve the needs of the older adult population
- Identify current funding sources
- Identify where additional funds may be needed to serve the needs of the older adult population

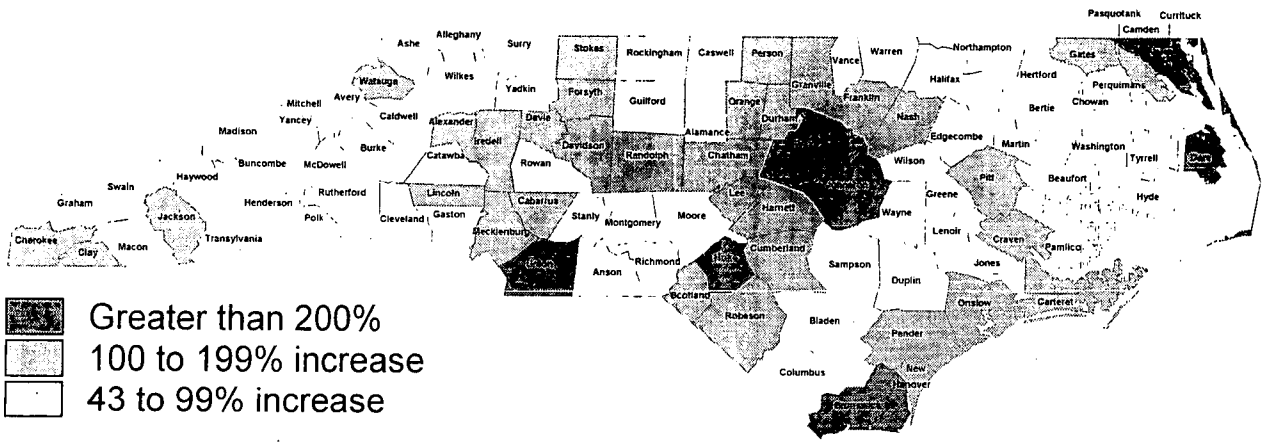
The bill further directs the Department to report its findings and recommendations to the 2008 General Assembly, the North Carolina Study Commission on Aging, and the board of county commissioners of the counties selected by April 1, 2008.

EFFECTIVE DATE: This act becomes effective July 1, 2007.

BACKGROUND:

Based on **Aging North Carolina -2007 Profile**[1] published in the 2006-07 North Carolina Study Commission on Aging's final report to the Governor and 2007 General Assembly, four counties Brunswick, Camden, Currituck, and Dare are projected to see disproportionate growth in their aging population. Brunswick and Dare, in particular, are projected to have substantially higher percentages of older adults (26.4 percent and 24.1 percent respectively), compared to 17.7 percent for the state as a whole.

Projected Growth of Population Ages 65 and Older from 2000 to 2030



Based on 2000 Census counts (www.census.gov) and April 2030 projections (2006, Demographic Unit, Office of State Budget and Management

S0448e1-SMSQ-CSSQ-6

[1] Prepared by the Department of Health and Human Services, Division on Aging and Adult Services

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 448
PROPOSED COMMITTEE SUBSTITUTE S448-CSSQ-6 [v.6]

3/20/2007 5:53:13 PM

Short Title: Study/Brunswick County. (Public)

Sponsors:

Referred to:

March 5, 2007

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND IDENTIFY PROGRAM AND SERVICE NEEDS FOR OLDER ADULTS IN BRUNSWICK AND OTHER COUNTIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Aging and Adult Services, shall study the population profile of Brunswick County and other counties where there is expected to be a significant increase in the number of individuals who are 65 years old or older. The purpose of the study is to determine the anticipated impact on programs and services that address the needs of the older adult population. The study shall identify programs that are currently in place, or are needed, in order to address the needs of the older adult population and shall make recommendations for improved delivery systems. The study shall also identify current funding sources and where additional funds are needed. The Department shall report its findings and recommendations not later than April 1, 2008, to the 2008 Regular Session of the 2007 General Assembly, to the North Carolina Study Commission on Aging, and to the board of county commissioners of each county studied.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 448
PROPOSED COMMITTEE SUBSTITUTE S448-PCS55388-SQ-6

Short Title: Study/Brunswick County. (Public)

Sponsors:

Referred to:

March 5, 2007

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND IDENTIFY PROGRAM AND SERVICE NEEDS FOR OLDER ADULTS IN BRUNSWICK AND OTHER COUNTIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Aging and Adult Services, shall study the population profile of Brunswick County and other counties where there is expected to be a significant increase in the number of individuals who are 65 years old or older. The purpose of the study is to determine the anticipated impact on programs and services that address the needs of the older adult population. The study shall identify programs that are currently in place, or are needed, in order to address the needs of the older adult population and shall make recommendations for improved delivery systems. The study shall also identify current funding sources and where additional funds are needed. The Department shall report its findings and recommendations not later than April 1, 2008, to the 2008 Regular Session of the 2007 General Assembly, to the North Carolina Study Commission on Aging, and to the board of county commissioners of each county studied.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 666

Short Title:	Expand NC Institute of Medicine Membership.	(Public)
Sponsors:	Senator Garrou.	
Referred to:	Health Care.	

March 12, 2007

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE AN EXPANSION OF THE MEMBERSHIP OF THE NORTH CAROLINA INSTITUTE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-470 reads as rewritten:

"**§ 90-470. Institute of Medicine.**

The persons appointed under the provisions of this section are declared to be a body politic and corporate under the name and style of the North Carolina Institute of Medicine, and by that name may sue and be sued, make and use a corporate seal and alter the same at pleasure, contract and be contracted with, and shall have and enjoy all the rights and privileges necessary for the purposes of this section. The corporation shall have perpetual succession.

The purposes for which the corporation is organized are to:

(1) Be concerned with the health of the people of North Carolina;

(2) Monitor and study health matters;

(3) Respond authoritatively when found advisable;

(4) Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions.

The 18 initial members of the North Carolina Institute of Medicine shall be appointed by the Governor.

The initial members are authorized, prior to expanding the membership, to establish bylaws, to procure facilities, employ a director and staff, to solicit, receive and administer funds in the name of the North Carolina Institute of Medicine, and carry out other activities necessary to fulfill the purposes of this section.

The members shall select with the approval of the Governor additional members, ~~so that the total membership will not exceed 100.~~ so that the total membership will not exceed a number determined by the Board of Directors in its bylaws. The membership should be distinguished and influential leaders from the major health professions, the hospital industry, the health insurance industry, State and county government and other

political units, education, business and industry, the universities, and the university medical centers.

The North Carolina Institute of Medicine may receive and administer funds from private sources, foundations, State and county governments, federal agencies, and professional organizations.

The director and staff of the North Carolina Institute of Medicine should be chosen from those well established in the field of health promotion and medical care.

For the purposes of Chapter 55A of the General Statutes, the members appointed under this section shall be considered the initial board of directors.

The North Carolina Institute of Medicine is declared to be under the patronage and control of the State.

The General Assembly reserves the right to alter, amend, or repeal this section."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 666
PROPOSED COMMITTEE SUBSTITUTE S666-PCS35340-SQ-4

Short Title: Expand NC Institute of Medicine Membership. (Public)

Sponsors:

Referred to:

March 12, 2007

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE AN EXPANSION OF THE MEMBERSHIP OF THE NORTH CAROLINA INSTITUTE OF MEDICINE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-470 reads as rewritten:

"**§ 90-470. Institute of Medicine.**

The persons appointed under the provisions of this section are declared to be a body politic and corporate under the name and style of the North Carolina Institute of Medicine, and by that name may sue and be sued, make and use a corporate seal and alter the same at pleasure, contract and be contracted with, and shall have and enjoy all the rights and privileges necessary for the purposes of this section. The corporation shall have perpetual succession.

The purposes for which the corporation is organized are to:

(1) Be concerned with the health of the people of North Carolina;

(2) Monitor and study health matters;

(3) Respond authoritatively when found advisable;

(4) Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions.

The 18 initial members of the North Carolina Institute of Medicine shall be appointed by the Governor.

The initial members are authorized, prior to expanding the membership, to establish bylaws, to procure facilities, employ a director and staff, to solicit, receive and administer funds in the name of the North Carolina Institute of Medicine, and carry out other activities necessary to fulfill the purposes of this section.

The members shall select with the approval of the Governor additional members, ~~so that the total membership will not exceed 100.~~ so that the total membership will not exceed a number determined by the Board of Directors in its bylaws. The membership should be distinguished and influential leaders from the major health professions, the

hospital industry, the health insurance industry, State and county government and other political units, education, business and industry, the universities, and the university medical centers.

The North Carolina Institute of Medicine may receive and administer funds from private sources, foundations, State and county governments, federal agencies, and professional organizations.

The director and staff of the North Carolina Institute of Medicine should be chosen from those well established in the field of health promotion and medical care.

For the purposes of Chapter 55A of the General Statutes, the members appointed under this section shall be considered the initial board of directors.

The North Carolina Institute of Medicine is declared to be under the patronage and control of the State.

The General Assembly reserves the right to alter, amend, or repeal this section."

SECTION 2. This act is effective when it becomes law and applies to appointments made on or after this date.

SENATE BILL 666:
Expand NC Institute of Medicine Membership

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	March 19, 2007
Introduced by:	Sen. Garrou	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 666 would remove the 100 member limit and direct the Board of Directors to determine the total membership in its bylaws.

CURRENT LAW:

G.S. 90-470 governs the Institute of Medicine. The Institute is organized to do all of the following:

- Be concerned with the health of the people of North Carolina
- Monitor and study health matters
- Respond authoritatively when advisable
- Respond to requests from outside sources for analysis and advice to aid health policy decisions.

Membership is composed of distinguished and influential leaders from the major health professions, the hospital industry, the health insurance industry, State and county government and other political units, education, business and industry, the universities, and the university medical centers. Total membership not to exceed 100 members.

EFFECTIVE DATE: This act is effective when it becomes law.

S0666e1-SMSQ

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 666

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

S666-ASQ-3 [v.1]

Date _____,2007

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Senator _____

moves to amend the bill on page 2, line 13 by rewriting the line to read:

"**SECTION 2.** This act is effective when it becomes law and applies to appointments made on or after this date.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

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

MARCH 21, 2007 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
April Culver	Johnston Memorial Hospital
Martha McConnell	Carolinas HealthCare System
[illegible]	HHS
Dennis Streets	DAAS-DHHS
Mac Martin	Caring Services, Inc.
Becky Yates	Caring Services Inc High Point NC
Jennifer E Yates, MD	Doctor for the Day New Hanover Regional Medical Center
Paige Johnson	Planned Parenthood
Pam Silberman	NC Inst. of Medicine
Becki Gray	John Locke Foundation
Cam Cole	BCBSNC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 21, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cliff Vanable	Govs office
Sarah Price	BGA
K Shipley	Schering Corporation
Selena Berman	child Fatality Task Force
PAUL LANIER	Child Fatality Task Force
Larry Michael	DENR
Elizabeth Self	DENR
Susan Grayson	DENR
Chris Hoke	DHHS
Abby Emanuel	NASS
Darrell Jernigan	GHSP

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 21, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shannon Ballard	GTHSP
Bill Hake	UNC Highway Safety Res. Ctr Chapel Hill
[illegible]	[illegible]
DAVID BARNES	Poyner Spruill
[illegible]	DHHR
[illegible]	[illegible]
[illegible]	DVE
John Bowdish	Astra Zeneca
Judy McConnell	IOG
Frank W. Folger	Helms Mullis Wicker
Rose Williams	Dept. of Insurance

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **MARCH 21, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angie Hamm	Williams Mullen
Steve Shaw	NC Pediatric Society
Al Ripley	NC Justice Ctr

Senate Health Care Committee
Wednesday, April 4, 2007, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 243	**DHHS/Office of Men's Health.**	**Senator Forrester**
SB 337	**Mental Health/LME Board Structure.**	**Senator Snow**
SB 748	**Extend Restriction on Home Care Licenses.**	**Senator Dannelly**
SB 836	**Food Stamps/TANF Technical Changes.**	**Senator Jones**
SB 1086	**Tobacco Free Schools.**	**Senator Purcell**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, April 4, 2007 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on Wednesday, April 4, 2007, in Room 544 of the Legislative Office Building. Ten members of the committee were present and Sen. Stan Bingham presided. Senator Bingham and Senator Dr. William R. Purcell, Co-Chairs, welcomed the members and introduced the pages and sergeants-at-arms.

Senator Stan Bingham brought before the committee, SB 243, ***DHHS/Office of Men's Health***, for discussion only. Sen. Dr. Forrester stated SB 243 would create an office of Men's Health, which would be very similar to a bill that he proposed ten years ago creating an office of Women's Health that was the second office of Women's Health in the nation behind California. Now thirty-nine states have offices of Women's Health. This bill is a specific bill that would promote men's issues because men live shorter and unhealthier lives compared to women and die six years younger. This would help educate men, their families, and physicians about the importance of closing the gaps in health care between men and women. It would encourage men to get regular medical check-ups and screenings, exercise, healthy eating habits, and would help save lives by early detection. It would zoom in on Prostate Cancer, which is a real killer in our state. There were about 7,000 cases of Prostate Cancer last year in NC and almost 1,000 deaths in Prostate Cancer only. SB 243 has been discussed in detail with Secretary Odom who has agreed to help with the bill. Sen. Dr. Forrester knows of no opposition, however, there was a question from someone about paying for the bill. Sen. Forrester stated he would be glad to answer any questions or move on to some of the other bills. Sen. Dannelly asked about paying for the bill and stated you either pay less upfront or more at the end.

Senator Snow was recognized to present SB 337, ***Mental Health/LME Board Structure.*** Sen. Nesbitt made the motion to hear the PCS for SB 337 and the motion carried. Sen. Snow stated the bill had to do with the board structures for the LMEs, Local Management Entity. This Proposed Committee Substitute for SB 337 clarifies that the term limitations for area authority board members shall not apply if the member counties of a multi-county area authority: number one, adopt a resolution providing an alternative method for selecting the members of the area authority board; and number two, include the alternative method in their local business plan. The method for selection is very complicated. The Western Highlands, Transylvania County, people have been in a practice of having their county manager to sit on this board rather than having a county commissioner, and their logic in the practice was that the county manager was paid to keep up with this stuff and to be at the meetings. This bill would allow the county manager to serve on this board for consecutive terms. Sen. Brunstetter asked if this would apply to any citizen appointee. Sen. Snow replied that any LME can set a resolution and set it up almost anyway they want, as long as they do it as it is in the Statute now. The issue in this bill would address if they could serve more that one term. Sen. Brunstetter asked if a multi-county

LME structure can opt out of term limits and other LMEs cannot opt out of term limits. Kory Goldsmith, Research Attorney, stated that was correct. Sen. Snow repeated the fact is to be able to serve consecutive terms. Sen. Brunstetter indicated his concern was about setting up to two different policy standards, not the consecutive terms. Sen. Snow said he understood in the single county districts they are set up differently and there are no provisions for any kind of resolution. Kory Goldsmith, Research Staff, replied that was correct. The statute is already set up to treat people differently. Sen. Snow stated his request came from the County Commissioners and they have been having their County Manager serve on the board simply because he is in the best position to retain the information given and will be there and involved for several years. After much discussion, the bill was displaced until another day.

Senator Dannelly was recognized to explain SB 748, ***Extend Restriction on Home Care Licenses.*** Sen. Dannelly stated SB 748 requested exactly what the title says. A number of new Home Care Rules were implemented in 2006 and as a result of the 2005 Legislative actions the providers are still getting accustomed to the rules, and more time for the implementation of the rules would be beneficial to providers as well as the regulator perspective. There is currently no evidence in the state that there is an access problem. Every county has multiple agencies located in the counties for patients to choose. In simple terms, another year is needed to implement the rules because they are rather stringent. Senator Malone moved for a favorable report. Sen. Bingham asked if there were any questions. No questions were asked and the bill passed.

Senator Bingham asked for a motion to adopt the Proposed Committee Substitute for SB 836, ***Food Stamps/TANF Technical Changes***, for discussion. Sen. Dorsett made the motion, which passed. Sen. Jones was recognized to present his bill. Sen. Jones stated this was a simple bill asking to change the name from the Food Stamp Program to the Nutrition Services anywhere it may apply in the General Statutes. Sen. Dorsett made the motion, unfavorable as to bill, but favorable as to the Committee Substitute Bill. The motion carried.

Senator Bingham asked for a motion to adopt the Proposed Committee Substitute for SB 1086, ***Tobacco Free Schools***, for discussion. Senator Dannelly made the motion, which passed. Senator Dr. Purcell was recognized to present his bill. He stated the bill would do exactly what the full title stated and that it is in line with what 83 school systems have already adopted. The bill requires local public school boards of education to adopt comprehensive tobacco free policies that will prohibit tobacco use at any time by students, staff members, or school visitors in school buildings, school facilities, on school grounds, and at school sponsored events. The purpose of the bill is not to be punitive. When someone is using tobacco they may be simply reminded of the policy and asked to refrain while on the school grounds or events and this usually works. Senator Dr. Purcell asked for permission for a couple of people to speak. Sen. Dannelly moved for a favorable report at the appropriate time. Sen. Bingham called on Mark Ezell, Director of the States' 100% Tobacco Free Schools Program. He stated that this was a joint project of the NC Health and Wellness Trust Fund in partnership with the Tobacco Prevention and Control Branch. There were only 14 school districts across the state that had a tobacco free school policy; now there are 83 school districts that have the policy. There is research that shows school districts that have had this policy for 3 or more years have 40% fewer

smokers than places that do not. Sen. Bingham noted the impressive numbers. He then called on Leanne Winner, NC School Boards Association, who pointed out that the statutes as they currently stand on the books, were very carefully negated several years ago between the school boards association and the health and wellness trust funds. Ms. Winner stated it has given the school districts the flexibility to work within their community to make progress on having their policy banning smoking. The current law does ban smoking completely in any enclosed buildings. Sen. Berger asked for staff to identify the 17 counties that have not adopted the policy. Shawn Parker, Research Staff, stated there was a map available with that information (included with minutes). Sen. Jacumin stated he had worked with Booster Clubs for thirty years and there were people who chewed tobacco, which did not harm other people. Senator Kinnaird stated that we pay for this when people have cancer of the lips and cheeks with Medicaid. Senator Berger pointed out the issue of local control. The issue should be left for local control. Sen. Berger reminded folks that tobacco is a legal product and that the school systems in the state were built with tobacco money. He also noted that no one should smoke in the classrooms. Sen. Berger also pointed out there was an issue of worker rights; when they have a break they like to smoke. A mandate from the state is the wrong way to go. Sen. Dr. Purcell stated the thing that prompted the number of bills dealing with smoking was the Surgeon General's Report on the danger of second hand smoke. Also he pointed out the teachers are supposed to be role models. Sen. Kinnaird asked Mr. Ezell if there was any reduction of student asthma. Mr. Ezell stated there is none that he knows of, but there are studies out that 95% of North Carolinians, regardless of where they live, support 100% tobacco free schools. Sen. Berger stated that under current law you could not smoke in school buildings. This bill prevents a teacher from going outside away from the students and smoking a cigarette. The school board should be able to make this decision. Sen. Nesbitt asked what the current law is on all buildings. Mr. Ezell responded that right now Federal Law Prohibits Smoking inside of school buildings, but stated this policy will be much more restrictive. Sen. Bingham stated there was a motion from Sen. Dannelly, unfavorable as to bill, but favorable as to committee substitute bill. The motion passed.

The meeting adjourned at 11:55 A.M.

Senator Stan Bingham, Co-Chair

Senator Dr. William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, April 04, 2007

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

FAVORABLE

S.B. **748** Extend Restriction on Home Care Licenses.
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

Wednesday, April 04, 2007

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

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

S.B. **836** Food Stamps/TANF Technical Changes.

Draft Number:	PCS55415
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

Tuesday, April 10, 2007

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

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

S.B. **1086** Tobacco Free Schools.

Draft Number:	PCS15067
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 243

Short Title:	DHHS/Office of Men's Health.	(Public)
Sponsors:	Senators Forrester; Bingham, Brunstetter, Dannelly, Foriest, Goodall, Hoyle, Jones, Purcell, Smith, Stevens, and Tillman.	
Referred to:	Health Care.	

February 21, 2007

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES THE OFFICE OF MEN'S HEALTH.

Whereas, a silent health crisis is affecting the health and well-being of America's men; and

Whereas, while this health crisis is of particular concern to men, it is also a concern for women regarding the health of their fathers, husbands, sons, and brothers; and

Whereas, men's health is a concern for employers who pay the costs of medical care and lose productive employees; and

Whereas, men's health is a concern to federal and state governments, which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind; and

Whereas, appropriate use of tests such as prostate specific antigen (PSA) exams, and blood pressure, blood sugar, and cholesterol screens, in conjunction with clinical exams and self-testing, can result in the early detection of many problems and in increased survival rates; and

Whereas, educating men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of America's men and America's overall economic well-being; and

Whereas, recent scientific studies have shown that regular medical exams, preventive screenings, regular exercise, and healthy eating habits can help save lives; and

Whereas, establishing an Office of Men's Health is needed to investigate these scientific study findings and take such further actions as may be needed to promote men's health; Now, therefore,

The General Assembly of North Carolina enacts:

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

"Article 5A.

"Men's Health.

"**§ 130A-131.26. Office of Men's Health established.**

(a) There is established in the Department the Office of Men's Health. The purpose of the office is to expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of men. The primary goals of the Office shall be the prevention of disease and improvement in the quality of life for men over their entire lifespan. The Department shall develop strategies for achieving these goals which shall include, but not be limited to:

(1) Developing a strategic plan to improve public services and programs targeting men;

(2) Conducting policy analyses on specific issues related to men's health;

(3) Facilitating communication among the Department's programs and between the Department and external men's health groups and community-based organizations;

(4) Building public health awareness and capacity regarding men's health issues by providing a series of services including evaluation, recommendation, technical assistance, and training; and

(5) Developing initiatives for modification or expansion of health services oriented towards men's health issues with the intent of establishing meaningful public/private partnerships in the future.

(b) The Office shall study the feasibility of establishing initiatives for:

(1) Early intervention services for men infected with HIV; and

(2) Outreach, treatment, and follow-up services to men at high risk for contracting sexually transmitted diseases.

In conducting the study, the Department shall take into consideration related services already in place in the Department and at the local level."

SECTION 2. The Department of Health and Human Services shall use funds available for the 2007-2008 and 2008-2009 fiscal years to implement this act.

SECTION 3. This act becomes effective July 1, 2007.

SENATE BILL 243:
DHHS/Office of Men's Health

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 3, 2007
Introduced by:	Sen. Forrester	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 243 would enact a new Article 5A (Men's Health) of Chapter 130A (Public Health) that would establish the Office of Men's Health. The Office would be housed within the Department of Health and Human Services and would have as its primary goals "...the prevention of disease and improvement in the quality of life for men over their entire lifespan."[1]

Senate Bill 243 would direct the Department to use funds available for the 2007-2008 and 2008-2009 fiscal years to implement the provisions of the act.

BILL ANALYSIS: Senate Bill 243 would enact a new Article 5A (Men's Health) of Chapter 130A (Public Health) that would establish the Office of Men's Health. The Office would be housed within the Department of Health and Human Services and would be charged with "...expand(ing) the State's public health concerns and focus to include a comprehensive outlook on the overall health status of men."[2]

The bill would direct the Department to:

- Develop strategies for achieving the goals of preventing disease and improving the quality of life for men over their entire lifespan; and
- Study the feasibility of establishing initiatives for early intervention services for men infected with HIV and providing outreach, treatment and follow-up services to men at high risk of contracting sexually transmitted diseases.

Senate Bill 243 would direct the Department to use funds available for the 2007-2008 and 2008-2009 fiscal years to implement the provisions of the act.

EFFECTIVE DATE: This act becomes effective July 1, 2007.

S0243e1-SMRD

[1] Proposed G.S. 130A-131.26(a).
[2] Proposed G.S. 130A-131.26(a).

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007

S 1

SENATE BILL 337*

Short Title:	Mental Health/LME Board Structure.	(Public)
Sponsors:	Senator Snow.	
Referred to:	Health Care.	

February 27, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STRUCTURE OF LOCAL MANAGEMENT ENTITY BOARDS PERTAINING TO THE SERVICE OF COUNTY COMMISSIONERS.

The General Assembly of North Carolina enacts:

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

"(d) Any member of an area board who is a county commissioner or commissioner designee serves on the board in an ex officio capacity. The terms of county commissioners or their designees 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 three years, except that upon the initial formation of an area board one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members~~ Members, other than a county commissioner or the designee thereof, shall not be appointed for more than two consecutive terms. Board ~~members~~ members, other than a county commissioner or designee thereof, serving as of July 1, 2006, may remain on the board for one additional term."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 337*
PROPOSED COMMITTEE SUBSTITUTE S337-PCS55401-RC-5

Short Title: Mental Health/LME Board Structure. (Public)

Sponsors:

Referred to:

February 27, 2007

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE PROCESS BY WHICH BOARDS OF COUNTY COMMISSIONERS MAY APPOINT MEMBERS TO A MULTICOUNTY AREA AUTHORITY BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-118.1 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,~~ provided in subsection (a1) of this section, 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, representation of the disability groups, and equitable representation of participating counties.~~ Individuals appointed to the board shall include two individuals with financial 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.

(a1) The boards of county commissioners within a multicounty area authority may appoint the members of the area board in a manner other than is required under this section if each board of county commissioners adopts a resolution specifying how the area board will be appointed. Pursuant to G.S. 122C-115.2(b), the boards of county commissioners in a multicounty area authority shall also indicate in the local business plan each board's method of appointment of the area board members. The appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. The term limitations in subsection (d) of this section shall not apply to appointments made according to resolutions adopted under this subsection and included in an area authority's local business plan.

(b) 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) At least one family member or individual from a citizens' organization composed primarily of consumers or their family members, representing the interests of individuals:
   a. With mental illness;
   b. In recovery from addiction; or
   c. With developmental disabilities.

(4) At least one openly declared consumer:
   a. With mental illness;
   b. With developmental 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 two categories of membership if the member has the qualifications or attributes of 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 three years, except that upon the initial formation of an area board one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members~~ Except as provided in subsection (a1) of this section, members 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 2. This act is effective when it becomes law. A multicounty area authority may amend its local business plan to reflect appointments made pursuant to this act.

SENATE BILL 337:
Mental Health/LME Board Structure

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 4, 2007
Introduced by:	Sen. Snow	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition S337-PCS55401-RC-5		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for Senate Bill 337 clarifies that the term limitations for area authority board members shall not apply if the member counties of a multi-county area authority: (i) adopt a resolution providing an alternative method for selecting the members of the area authority board; and (ii) include the alternative method in the local business plan.***

The PCS completely rewrites the 1st Edition.

The act would be effective when it becomes law. Area authorities would be allowed to amend their local business plans to reflect appointments

CURRENT LAW: There are six different governance models for the local agencies (LMEs) that oversee the provision of public mental health, developmental disabilities, and substance abuse services (MH/DD/SAS). The board(s) of county commissioners of each county within an LME catchment area determine the type of governance structure the LME will have.

The governance models are:

- single county area authority;
- multi-county area authority;
- single county county program;
- multi-county county program;
- Mecklenburg County; and
- Consolidated human services board (Wake County).

As of July 1, 2007, 23 out of 25 LMEs will be structured as area authorities.

G.S. 122C-118.1(a) governs the selection and membership of area authority boards. An area authority board must have at least 11 members and may have up to 30 members. There are three different methods by which an area authority board is selected.

- If the area authority is comprised of a single county, then the members of the area authority board are selected by the board of county commissioners of that county.
- If the area authority contains more than one county, then:

  – the boards of county commissioners of each county select one commissioner from each county to be on the area authority board. Those commissioners then appoint other members; or

– the member boards of county commissioners pass a resolution setting out a different method of appointment and include that method in the local business plan that is submitted to the State.[1]

If the board membership is selected under the statutory methods, it must include at least 2 individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children.[2] Up to 50% of the board shall include:

- A physician licensed to practice medicine in North Carolina (preferably a psychiatrist);
- A clinical professional in the field of MH/DD/SAS;
- At least one family member or individual from a citizens group representing the interests of each disability group; and
- At least one openly declared consumer from each disability group.[3]

If the area authority board is selected according to a resolution passed by all member counties, then the statutory membership requirements do not apply.[4] However, the appointments must take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties.

Members serve for 3 year terms.[5] Prior to 2006, all members except county commissioners were limited to no more than 2 consecutive terms. In 2006, the Joint Legislative Oversight Committee for MH/DD/SAS recommended, and the General Assembly passed, legislation that made the 2 consecutive term limitation applicable to county commissioners.[6]

It is not clear whether the term limitations in G.S. 122C-118.1(d) apply to multi-county area authority boards whose members are appointed pursuant to county-adopted resolutions.

BILL ANALYSIS: The Proposed Committee Substitute to SB337 creates a new subsection (a1) in G.S. 122C-118.1. The subsection moves existing language from subsection (a) regarding the process by which the member counties of a multi-county area authority may pass a resolution providing for an appointment method for the area authority board that differs from the statutory method. Subsection (a1) also makes it clear that the term limitations contained in G.S. 122C-118.1(d) do not apply to those area authority board members.

S0337e1-SMRC-PCS55401-RC-5

[1] See also G.S. 122C-115.2(b).
[2] 122C-118.1(a).
[3] 122C-188.1(b).
[4] 122C-118.1(a).
[5] 122C-118.1(d).
[6] (S.L. 2006-142; HB2077).

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 748

Short Title:	Extend Restriction on Home Care Licenses.	(Public)
Sponsors:	Senators Dannelly; Allran, Bingham, Dorsett, Malone, and Purcell.	
Referred to:	Health Care.	

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXTEND THE RESTRICTION ON THE ISSUING OF LICENSES FOR HOME CARE AGENCIES BY ONE YEAR.

The General Assembly of North Carolina enacts:

SECTION 1. Section 2 of S.L. 2006-194 reads as rewritten:

"**SECTION 2.** Beginning January 1, 2007, and for a period of ~~one year~~two years 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 2. This act is effective when it becomes law.

SENATE BILL 748:
Extend Restriction on Home Care Licenses

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 2, 2007
Introduced by:	Sen. Dannelly	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: Senate Bill 748 would extend the time period, from one year to two years, during which the Department of Health and Human Services is restricted from issuing licenses for home care agencies offering in-home aide services.

[As introduced, this bill was identical to H826, as introduced by Reps. Clary, Earle, Alexander, Farmer-Butterfield, which is currently in House Aging.]

CURRENT LAW:

G.S. 131E-136 Definitions

- "*Home care agency*" – defined in G.S. 131E-136 (2) as a private or public organization that provides home care services.
- "*In-home aide services*" – defined in G.S. 131E-136(3)(d) as services that involve hands-on care to an individual in a place of temporary or permanent residence used as an individual's home.
- "*Home health agency*" – defined in G.S. 131E-136(4) as a home care agency 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.

Section 2, Session Law 2006-194

Section 2 of S.L. 2006-194 prevents the Department of Health and Human Services from issuing licenses for a one year period for new home care agencies that intend to offer in-home aide services. The restriction does not apply to certified home health agencies or agencies that need a new license for an existing home care agency being acquired. Section 2 of S.L. 2006-194 provides that the restriction on issuing licenses was needed to allow the Department time to implement newly adopted home care rules. The one year period authorized by this act began on January 1, 2007.

BILL ANALYSIS:

Senate Bill 748 would amend Section 2 of S.L. 2006-194 to lengthen, from one year to two years, the period during which the Department of Health and Human Services would be restricted from issuing licenses for new home care agencies that intend to offer in-home aide services. This would extend the restriction that began on January 1, 2007 to the end of the 2008 calendar year.

EFFECTIVE DATE:

The bill is effective when it becomes law.

Theresa Matula, Legislative Analyst to House Aging, substantially contributed to this summary.

S0748e1-SMRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 836*

Short Title:	Food Stamps/TANF Technical Changes.	(Public)
Sponsors:	Senator Jones.	
Referred to:	Health Care.	

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO RENAME THE FOOD STAMP PROGRAM TO BE CONSISTENT WITH FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Part 5 of Article 2 of Chapter 108A of the General Statutes and G.S. 108A-51 read as rewritten:

"Part 5. Food ~~Stamp Program.~~and Nutrition Services.

"**§ 108A-51. Authorization for Food ~~Stamp Program.~~and Nutrition Services.**

The Department is authorized to establish a statewide food ~~stamp program~~ and nutrition services authorized by the Congress of the United States. The program shall be named "Food Assistance in North Carolina." The Department of Health and Human Services is designated as the State agency responsible for the supervision of ~~such programs.~~ food and nutrition services. The boards of county commissioners through the county departments of social services are held responsible for the administration and operation of ~~the programs.~~ food and nutrition services."

SECTION 2. Wherever the terms "food stamp," "food stamps," or "food stamp program" appear in the General Statutes, the Revisor of Statutes shall replace "food stamp," "food stamps," or "food stamp program" with "food and nutrition services."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 836*
PROPOSED COMMITTEE SUBSTITUTE S836-CSSQ-10 [v.3]

4/3/2007 4:16:44 PM

Short Title: Rename Food Stamp Program. (Public)

Sponsors:

Referred to:

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO RENAME THE FOOD STAMP PROGRAM TO REFLECT THE USE OF ELECTRONIC BENEFIT TRANSFER CARDS.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Part 5 of Article 2 of Chapter 108A of the General Statutes and G.S. 108A-51 read as rewritten:

"Part 5. Food ~~Stamp Program.~~and Nutrition Services.

"**§ 108A-51. Authorization for Food ~~Stamp Program.~~and Nutrition Services.**

The Department is authorized to establish ~~a~~ statewide food ~~stamp program~~ and nutrition services authorized by the Congress of the United States. The program shall be named "Food and Nutrition Services." The Department of Health and Human Services is designated as the State agency responsible for the supervision of ~~such programs.~~ food and nutrition services. The boards of county commissioners through the county departments of social services are held responsible for the administration and operation of ~~the programs.~~food and nutrition services."

SECTION 2. Wherever the terms "food stamp," "food stamps," or "food stamp program" appear in the General Statutes, the Revisor of Statutes is authorized where appropriate to replace "food stamp," "food stamps," or "food stamp program" with "food and nutrition services" or "electronic food and nutrition benefits"."

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

SENATE BILL 836:
Rename Food Stamp Program

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 2, 2007
Introduced by:	Sen. Jones	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S836-CSSQ-10		Legislative Analyst

SUMMARY: Senate Bill 836 would rename the "Food Stamp Program" as "Food and Nutrition Services" and directs the Revisor of Statutes to make appropriate changes in the General Statutes.

The Proposed Committee Substitute would provide the Revisor of Statutes the authority to make changes in statute where appropriate and provides the option of using the term "electronic food and nutrition benefits" where appropriate.

[As introduced, this bill was identical to H719, as introduced by Reps. Earle, Lucas, which is currently in House Judiciary III.]

BACKGROUND:

The Food Stamp Program is a federal food assistance program that helps provide food assistance to low-income families. In North Carolina monthly allotments of Food Stamp benefits are issued via Electronic Benefit Transfer cards (EBT cards). The purpose of the Food Stamp Program is to end hunger and improve nutrition and health. It helps eligible low-income households buy the food they need for a nutritionally adequate diet.

The Food Stamp Program is an entitlement program, so all eligible individuals and households can receive assistance. Food Stamp benefits may be used to purchase most foods at participating stores. Food stamp benefits may not be used to purchase tobacco, pet food, paper products, soap products, or alcoholic beverages. [1]

BILL ANALYSIS:

The Proposed Committee Substitute renames the Food Stamp Program to Food and Nutrition Services and authorizes the Revisor of Statutes to replace in the General Statutes the terms "food stamp", "food stamps", and "food stamp program" with the terms "food and nutrition services" or "electronic food and nutrition benefits".

EFFECTIVE DATE: This act is effective when it becomes law.

S0836e1-SMSQ-CSSQ-10

[1] http://www.dhhs.state.nc.us./dss/foodstamp/index.htm accessed April 2, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 836*
PROPOSED COMMITTEE SUBSTITUTE S836-PCS55415-SQ-10

Short Title: Rename Food Stamp Program. (Public)

Sponsors:

Referred to:

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO RENAME THE FOOD STAMP PROGRAM TO REFLECT THE USE OF ELECTRONIC BENEFIT TRANSFER CARDS.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Part 5 of Article 2 of Chapter 108A of the General Statutes and G.S. 108A-51 read as rewritten:

"Part 5. Food ~~Stamp Program.~~and Nutrition Services.

"**§ 108A-51. Authorization for Food ~~Stamp Program.~~and Nutrition Services.**

The Department is authorized to establish ~~a~~ statewide food ~~stamp program~~ and nutrition services authorized by the Congress of the United States. The program shall be named "Food and Nutrition Services." The Department of Health and Human Services is designated as the State agency responsible for the supervision of ~~such programs.~~ food and nutrition services. The boards of county commissioners through the county departments of social services are held responsible for the administration and operation of ~~the programs.~~food and nutrition services."

SECTION 2. Wherever the terms "food stamp," "food stamps," or "food stamp program" appear in the General Statutes, the Revisor of Statutes is authorized where appropriate to replace "food stamp," "food stamps," or "food stamp program" with "food and nutrition services" or "electronic food and nutrition benefits."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1086

Short Title:	Tobacco Free Schools.	(Public)
Sponsors:	Senators Purcell; Albertson, Bingham, Dannelly, Forrester, Malone, and Rand.	
Referred to:	Health Care.	

March 21, 2007

A BILL TO BE ENTITLED

AN ACT TO PROTECT CHILDREN IN THE PUBLIC SCHOOLS FROM EXPOSURE TO TOBACCO BY REQUIRING LOCAL BOARDS OF EDUCATION TO ADOPT WRITTEN POLICIES PROHIBITING THE USE OF TOBACCO PRODUCTS BY ANY PERSON IN PUBLIC SCHOOL BUILDINGS AND SCHOOL FACILITIES, ON THE PUBLIC SCHOOL CAMPUS, AND IN OR ON OTHER SCHOOL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 155C-407 reads as rewritten:

"**§ 115C-407. Policy prohibiting tobacco use in school ~~buildings.~~buildings and the surrounding school campus.**

Local boards of education shall adopt and enforce a written policy ~~providing for enforcement of federal requirements under the Pro-Children Act of 1994, 20 U.S.C. § 6083, prohibiting smoking within any school building used to provide routine or regular kindergarten, elementary, or secondary education or library services to children.~~prohibiting at all times the use by any person of any tobacco product in a school building, school facility, on the surrounding public school campus, and in or on any other school property owned or operated by the local school administrative unit. The policy shall include at least the following:

~~The policy shall further prohibit the use of all tobacco products in enclosed school buildings during regular school hours, and shall include:~~

~~(1) Adequate notice to students and school personnel of the policy.~~

~~(2) Posting of signs regarding the use of tobacco products by any person.~~

~~(3) Requirements that school personnel enforce the policy.~~

(1a) Adequate notice to students and school personnel of the policy and sanctions for violation of the policy.

(2a) Posting signs prohibiting the use of tobacco products by any person at all times.

(3) Sanctions for violation of the policy by any person. Such sanctions may include participation in an approved smoking cessation program.

(4) Requirements that school personnel enforce the policy.

~~The policy may permit tobacco products to be included in instructional or research activities in public school buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.~~

Nothing in this section, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local board of education from adopting and enforcing a more restrictive policy on the use of tobacco in school buildings, in school facilities, on school campuses, or at school-related or school-sponsored events, and in or on other school property."

SECTION 2. This act is effective when it becomes law except that local boards of education shall have until January 1, 2008, to comply with G.S. 115C-407, as amended by this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1086
PROPOSED COMMITTEE SUBSTITUTE S1086-CSSQ-11 [v.4]

4/3/2007 4:20:33 PM

Short Title: Tobacco Free Schools. (Public)

Sponsors:

Referred to:

March 21, 2007

A BILL TO BE ENTITLED

AN ACT TO PROTECT CHILDREN IN THE PUBLIC SCHOOLS FROM EXPOSURE TO TOBACCO BY REQUIRING LOCAL BOARDS OF EDUCATION TO ADOPT WRITTEN POLICIES PROHIBITING THE USE OF TOBACCO PRODUCTS IN SCHOOL BUILDINGS, IN SCHOOL FACILITIES, ON SCHOOL CAMPUSES, OR AT SCHOOL-RELATED OR SCHOOL-SPONSORED EVENTS, AND IN OR ON OTHER SCHOOL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 155C-407 reads as rewritten:

"**§ 115C-407. Policy prohibiting tobacco use in school ~~buildings.~~buildings, grounds, and at school sponsored events.**

(a) Not later than August 1, 2008, ~~Local~~ local boards of education shall adopt, implement and enforce a written policy ~~providing for enforcement of federal requirements under the Pro-Children Act of 1994, 20 U.S.C. § 6083, prohibiting smoking within any school building used to provide routine or regular kindergarten, elementary, or secondary education or library services to children.~~prohibiting at all times the use of any tobacco product by any person in school buildings, in school facilities, on school campuses, and in or on any other school property owned or operated by the local school administrative unit. The policy shall further prohibit the use of all tobacco products ~~in enclosed school buildings during regular school hours, and shall include:~~ by persons attending a school sponsored event at a location not listed in this subsection.

(b) The policy shall include at least all of the following elements:

(1) Adequate notice to students, parents, the public, and school personnel of the policy.

(2) Posting of signs ~~regarding~~ prohibiting at all times the use of tobacco products by any ~~person.~~person in and on school property.

(3) Requirements that school personnel enforce the policy.

(c) The policy may permit tobacco products to be included in instructional or research activities in public school buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.

(d) The North Carolina Health and Wellness Trust Fund Commission shall work with local boards of education to provide assistance with the implementation of this policy including providing information regarding smoking cessation and prevention resources.

Nothing in this section, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local board of education from adopting and enforcing a more restrictive policy on the use of tobacco in school buildings, in school facilities, on school campuses, or at school-related or school-sponsored events, and in or on other school property."

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

SENATE BILL 1086:
Tobacco Free Schools

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 4, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S1086-CSSQ-11		Legislative Analyst

SUMMARY: ***Senate Bill 1086 would direct local boards of education to establish written policies prohibiting the use of tobacco by persons attending school-sponsored activities and would prohibit at all times the use of tobacco products in or on property owned or operated by the local school administrative unit.***

The bill would also direct the North Carolina Health and Wellness Trust Fund Commission to provide assistance to implement the policy.

CURRENT LAW:

Session Law 2003-421 established Article 29A in Chapter 155C of the General Statutes. These provisions direct local boards of education to adopt and enforce written policies prohibiting the use of tobacco products in enclosed school buildings during regular school hours and prohibiting smoking in school buildings. Local boards of education are allowed to adopt policies regarding tobacco use on other school properties and at school-sponsored events.

BILL ANALYSIS:

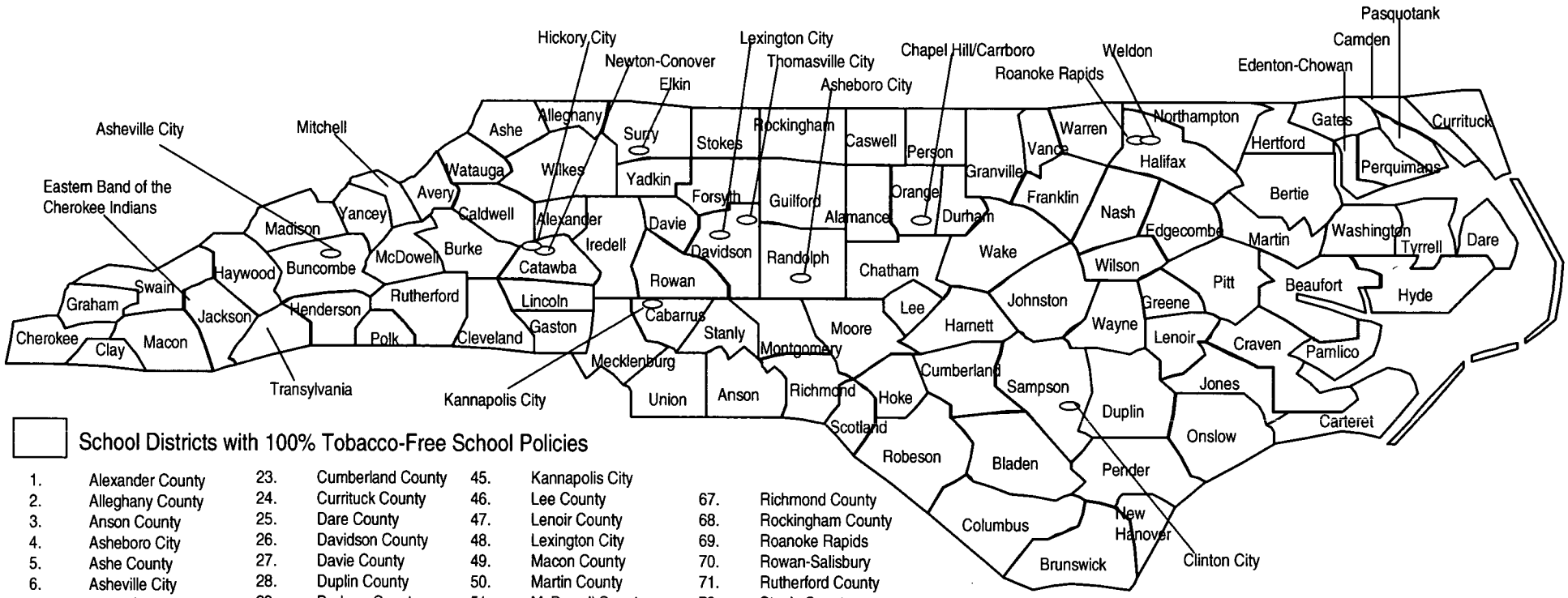
Senate Bill 1086 amends G.S. 155C-407 to direct local boards of education, not later than August 1, 2008, to expand the current statutory directive by adopting a policy that prohibits at all times the use of tobacco products in school buildings, in school facilities, on school campuses, and in or on any other school property owned or operated by the local school administrative unit. The bill requires the policy to include prohibiting the use of tobacco by persons attending a school-sponsored event.

The bill further amends G.S. 155C-407 by directing the North Carolina Health and Wellness Trust Fund Commission to provide assistance in implementing the policy including providing information regarding smoking cessation and prevention resources and make other technical changes.

EFFECTIVE DATE: This act is effective when it becomes law.

S1086e1-SMSQ-CSSQ-11

N.C. School Districts that Have Adopted a 100% Tobacco-Free School Policy: No Tobacco Use Anywhere, Anytime by Anyone – March 2007



School Districts with 100% Tobacco-Free School Policies

1. Alexander County
2. Alleghany County
3. Anson County
4. Asheboro City
5. Ashe County
6. Asheville City
7. Avery County
8. Bertie County
9. Buncombe County
10. Burke County
11. Caldwell County
12. Camden County
13. Carteret County
14. Catawba County
15. Chapel Hill-Carrboro
16. Charlotte-Mecklenburg
17. Chatham County
18. Cherokee County
19. Clay County
20. Cleveland County
21. Clinton City
22. Craven County
23. Cumberland County
24. Currituck County
25. Dare County
26. Davidson County
27. Davie County
28. Duplin County
29. Durham County
30. Edenton-Chowan
31. Elkin City
32. Gaston County
33. Gates County
34. Graham County
35. Granville County
36. Guilford County
37. Halifax County
38. Haywood County
39. Henderson County
40. Hertford County
41. Hickory City
42. Iredell-Statesville
43. Jackson County
44. Jones County
45. Kannapolis City
46. Lee County
47. Lenoir County
48. Lexington City
49. Macon County
50. Martin County
51. McDowell County
52. Mitchell County
53. Montgomery County
54. Moore County
55. Mew Hanover County
56. Newton-Conover City
57. Northampton County
58. Onslow County
59. Orange County
60. Pamlico County
61. Pasquotank County
62. Pender County
63. Perquimans County
64. Person County
65. Pitt County
66. Polk County
67. Richmond County
68. Rockingham County
69. Roanoke Rapids
70. Rowan-Salisbury
71. Rutherford County
72. Stanly County
73. Swain County
74. Thomasville City
75. Transylvania County
76. Tyrrell County
77. Union County
78. Vance County
79. Weldon City
80. Warren County
81. Washington County
82. Watauga County
83. Wilkes County

*The Eastern Band of the Cherokee Indians, a federally funded Native American School District, has also adopted a 100% Tobacco-Free School Policy

Source: NCTobaccoFreeSchools.com

Updated February 23, 2007

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1086
PROPOSED COMMITTEE SUBSTITUTE S1086-PCS15067-SQ-11

Short Title: Tobacco Free Schools. (Public)

Sponsors:

Referred to:

March 21, 2007

A BILL TO BE ENTITLED

AN ACT TO PROTECT CHILDREN IN THE PUBLIC SCHOOLS FROM EXPOSURE TO TOBACCO BY REQUIRING LOCAL BOARDS OF EDUCATION TO ADOPT WRITTEN POLICIES PROHIBITING THE USE OF TOBACCO PRODUCTS IN SCHOOL BUILDINGS, IN SCHOOL FACILITIES, ON SCHOOL CAMPUSES, OR AT SCHOOL-RELATED OR SCHOOL-SPONSORED EVENTS, AND IN OR ON OTHER SCHOOL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 155C-407 reads as rewritten:

"**§ 115C-407. Policy prohibiting tobacco use in school ~~buildings.~~buildings, grounds, and at school-sponsored events.**

(a) Not later than August 1, 2008, ~~Local~~ local boards of education shall ~~adopt~~ adopt, implement, and enforce a written policy ~~providing for enforcement of federal requirements under the Pro-Children Act of 1994, 20 U.S.C. § 6083, prohibiting smoking within any school building used to provide routine or regular kindergarten, elementary, or secondary education or library services to children.~~prohibiting at all times the use of any tobacco product by any person in school buildings, in school facilities, on school campuses, and in or on any other school property owned or operated by the local school administrative unit. The policy shall further prohibit the use of all tobacco products ~~in enclosed school buildings during regular school hours, and shall include:~~ by persons attending a school-sponsored event at a location not listed in this subsection.

(b) The policy shall include at least all of the following elements:

(1) Adequate notice to students, parents, the public, and school personnel of the policy.

(2) Posting of signs ~~regarding~~ prohibiting at all times the use of tobacco products by any ~~person.~~person in and on school property.

(3) Requirements that school personnel enforce the policy.

(c) The policy may permit tobacco products to be included in instructional or research activities in public school buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.

(d) The North Carolina Health and Wellness Trust Fund Commission shall work with local boards of education to provide assistance with the implementation of this policy including providing information regarding smoking cessation and prevention resources. Nothing in this section, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local board of education from adopting and enforcing a more restrictive policy on the use of tobacco in school buildings, in school facilities, on school campuses, or at school-related or school-sponsored events, and in or on other school property."

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

VISITOR REGISTRATION SHEET

Senate Health Care — **April 4, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Edgerton	DHHC
Jack Cozart	AHHC
Sheria Reid	IOG
Heather Parsons	DHHS
[illegible]	DHHS
[illegible]	NC DPH/DHHS
John Thompson	ACS
Mark Ezzell	AWTF
Ashley Bell	AHA/ASA
Keith Arbuckle	Home Care of the Carolinas Albemarle, NC
Brooke Ritchie	Home Care of the Carolinas Albemarle NC

VISITOR REGISTRATION SHEET

Senate Health Care — **April 4, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marilyn Farlow	Home Care of the Carolinas Albemarle NC
Elizabeth Outten	NC Alliance for Health
Bradley Foster	Maxim Healthcare Services
Mason Evans	Maxim Healthcare
Brian Curley	Maxim Healthcare Services
Kurt Jakusz	Health at Home Services Inc. Hickory
Valerie Kelly	Caldwell County Home Health - Lenoir
Melissa Briones	Caldwell County Home Health - Lenoir
Jon Hutchins	Governor's Institute on Alcohol and Substance Abuse
[illegible]	NC Med Society
[illegible]	NCACC

VISITOR REGISTRATION SHEET

Senate Health Care — **April 4, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bethany Carey	NC. Right to Life
Charlene Carey	NC Right to Life
Alex Goldstein	NC MHA
Robyn Bruce	NASW-NC
Katherine W. Joyce	NCASA
[illegible]	Poyner & Spruill
Patrick Baffa	NMRS
Leann Wines	NCSBA
Daniel Blum	Kennedy Covington
John Noble	Gov Office

Senate Health Care Committee
Wednesday, April 11, 2007, 11:00 AM
544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 337	Mental Health/LME Board Structure.	Senator Snow
HB 502	Repeal Chiropractic Special Provision.	Representative Holliman
HB 697	Clarify Authority of Social Services Comm.-AB	Representative Stam Representative Parmon Representative Barnhart Representative Goodwin Representative Glazier
HB 720	Name Change/Div. Faci. Svces/Commn. Hlth Svce.	Representative Earle Representative Lucas

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, April 11, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 11, 2007, in Room 544 of the Legislative Office Building, with sixteen members present, and Senator William R. Purcell presiding. Senator Purcell welcomed the committee members present, and introduced the pages and sergeants-at-arms, and welcomed a member new to the committee this session, Senator Austin Allran. Due to the illness of Co-Chair Senator Stan Bingham, Senator Jim Forrester served in his stead.

Senator Purcell recognized Representative Beverly Earle to speak on HB720, *Name Change/Div. Faci. Svces/Commn. Hlth Svce.* Senator Berger moved for a favorable report.

Senator Snow presented his bill, SB337, *Mental Health/LME Board Structure.* A PCS was introduced and voted on by the committee. Senator Dorsett asked if this bill would apply to boards statewide, and the response was that it would. Senator Forrester moved for a favorable report, unfavorable as to the original bill, favorable to the PCS.

Representative Hugh Holliman brought HB502, *Repeal Chiropractic Special Provision* to the committee. Senator Atwater moved for a favorable report.

Senator Purcell recognized Representative Rick Glazier for HB 697, *Clarify Authority of Social Services Comm.-AB.* A PCS was presented and adopted for discussion. Senator Hoyle moved for a favorable report as to the PCS, unfavorable as to the original bill.

The meeting adjourned at 11:20 A.M.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 12, 2007

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

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

S.B. **337** Mental Health/LME Board Structure.

Draft Number:	85299
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

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

H.B. **697** Clarify Authority of Social Services Comm.-AB

Draft Number:	50472
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

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, April 11, 2007

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

FAVORABLE

H.B.(CS #1) **502** Repeal Chiropractic Special Provision.
Sequential Referral: None
Recommended Referral: None

H.B.(CS #1) **720** Name Change/Div. Faci. Svces/Commn. Hlth Svce.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 337*

Short Title:	Mental Health/LME Board Structure.	(Public)
Sponsors:	Senator Snow.	
Referred to:	Health Care.	

February 27, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STRUCTURE OF LOCAL MANAGEMENT ENTITY BOARDS PERTAINING TO THE SERVICE OF COUNTY COMMISSIONERS.

The General Assembly of North Carolina enacts:

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

"(d) Any member of an area board who is a county commissioner or commissioner designee serves on the board in an ex officio capacity. The terms of county commissioners or their designees 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 three years, except that upon the initial formation of an area board one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members~~ Members, other than a county commissioner or the designee thereof, shall not be appointed for more than two consecutive terms. Board ~~members~~ members, other than a county commissioner or designee thereof, serving as of July 1, 2006, may remain on the board for one additional term."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 337*
PROPOSED COMMITTEE SUBSTITUTE S337-CSRC-10 [v.2]

4/10/2007 12:20:59 PM

Short Title: Mental Health/LME Board Structure. (Public)

Sponsors:

Referred to:

February 27, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STRUCTURE OF LOCAL MANAGEMENT ENTITY BOARDS PERTAINING TO THE SERVICE OF COUNTY MANAGERS.

The General Assembly of North Carolina enacts:

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

"(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 three years, except that upon the initial formation of an area board one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members~~ Members, other than a county manager, 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. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section."

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

SENATE BILL 337:
Mental Health/LME Board Structure

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 10, 2007
Introduced by:	Sen. Snow	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition S337-CSRC-10		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for Senate Bill 337 allows a county manager to serve indefinitely as a member of and area authority board. It also makes it clear that the term limitations for board members apply to all boards regardless of how the boards are appointed.***

The act would be effective when it becomes law.

CURRENT LAW: There are six different governance models for the local agencies (LME) that oversee the provision of public mental health, developmental disabilities, and substance abuse services (MH/DD/SAS). These are: (1) single county area authority; (2) multi-county area authority; (3) single county county program; (4) multi-county county program; (5) Mecklenburg County; and (6) consolidated human services board (Wake County). As of July 1, 2007, 23 out of 25 LMEs will be structured as area authorities. The boards of county commissioners of each county determine the governance structure the LME will have.

G.S. 122C-118.1(a) governs the selection of area authority boards. The board must have between 11 and 30 members. There are three different methods for appointing members:

- **Single County** - Members are selected by the board of county commissioners of that county.
- **Multi-County** – (1) Each board of county commissioners selects a commissioner. Those commissioners then appoint other members; or (2) each board of county commissioners adopts a resolution providing for a different method of appointment, then include that method in the local business plan.[1]

If the membership is appointed under one of the statutory methods, the board must include at least two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children.[2] Up to 50% of the board must include: a physician licensed to practice medicine in North Carolina; a clinical professional in the field of MH/DD/SAS; at least one family member or individual from a citizens group representing the interests of each disability group; and at least one openly declared consumer from each disability group.[3] If the area authority board is selected according to a resolution passed by all member counties, then the statutory membership requirements do not apply[4], but appointments must take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties.

Members serve for 3 year terms.[5] Prior to 2006, all members except county commissioners were limited to no more than 2 consecutive terms. In 2006, the Joint Legislative Oversight Committee for MH/DD/SAS recommended, and the General Assembly passed, legislation that made the 2 consecutive term limitation applicable to county commissioners.[6]

S0337e1-SMRC-CSRC-10

---

[1] See also G.S. 122C-115.2(b).
[2] 122C-118.1(a).
[3] 122C-118.1(b).
[4] 122C-118.1(a).
[5] 122C-118.1(d).
[6] (S.L. 2006-142; HB2077).

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 502

Committee Substitute Favorable 3/21/07

Short Title: Repeal Chiropractic Special Provision. (Public)

Sponsors:

Referred to:

March 7, 2007

A BILL TO BE ENTITLED

AN ACT TO REPEAL A BUDGET SPECIAL PROVISION CONCERNING HEALTH BENEFIT PLAN CO-PAYMENTS FOR CHIROPRACTIC SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Section 3(b) of S.L. 2005-345 is repealed.

SECTION 2. This act becomes effective October 1, 2007, and applies to policies issued or renewed on or after that date. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

HOUSE BILL 502:
Repeal Chiropractic Special Provision

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 9, 2007
Introduced by:	Reps. Holliman, Stam	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 502 would repeal the provision that prohibits an insurer from charging the insured a co-payment for chiropractic services in an amount that is higher than the co-payment charged to the insured for services of a licensed primary care physician.

CURRENT LAW:

Effective March 1, 2006, Section 3 of Session Law 2005-345 (HB 320, 2005 Budget Technical Corrections Act) amended G.S. 58-50-30(a3) to prohibit an insurer from imposing as a limitation on treatment or level of coverage a co-payment amount charged to the insured for chiropractic services that is higher than the amount charged to the insured for the services provided by a duly licensed primary care physician for comparable medically necessary treatment services.

BILL ANALYSIS:

House Bill 502 repeals Section 3(b) of Session Law 2005-345. For health benefit plan policies issued or renewed on or after October 1, 2007, insurers would be allowed to charge the insured a higher co-payment for services provided by chiropractors than the co-payment charged for services provided by primary care physicians for comparable medically necessary treatment.

EFFECTIVE DATE: This act becomes effective October 1, 2007 and applies to policies issued or renewed on or after this date. Renewal of a health benefit plan is presumed to occur on the anniversary of the date on which the coverage was first effective on the person(s) covered.

BACKGROUND: (Section 3 of S.L. 2005-345, House Bill 320)

SECTION 3.(a) Effective July 1, 2005, Section 6.29 of S.L. 2005-276 is repealed.

SECTION 3.(b) Effective March 1, 2006, G.S. 58-50-30(a3) reads as rewritten:

"(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician. An insurer shall not impose as a limitation on treatment or level of coverage a co-payment amount charged to the insured for chiropractic services that is higher than the co-payment amount charged to the insured for the services of a duly licensed primary care physician for a comparable medically necessary treatment or condition."

SECTION 3.(c) This sections applies to policies issued, renewed, or amended on or after March 1, 2006.

H0502e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 697

Short Title:	Clarify Authority of Social Services Comm.-AB	(Public)
Sponsors:	Representatives Glazier, Goodwin, Barnhart, Parmon (Primary Sponsors); Alexander, Carney, Harrison, Insko, Lucas, Wainwright, and Wray.	
Referred to:	Ways and Means.	

March 15, 2007

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE SOCIAL SERVICES COMMISSION TO ADOPT RULES ESTABLISHING EDUCATIONAL REQUIREMENTS FOR STAFF EMPLOYED BY MATERNITY HOMES, CHILD PLACING AGENCIES, AND RESIDENTIAL CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

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

"(a) The Department of Health and Human Services shall inspect and license all maternity homes established in the State under such rules and regulations as the Social Services Commission may ~~adopt.~~adopt, including rules establishing educational requirements for executive directors and staff employed in maternity homes."

SECTION 2. G.S. 131D-10.5 is amended by adding a new subdivision to read:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

...

(7) Adopt rules establishing educational requirements for executive directors and staff employed by child placing agencies and residential child care facilities."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 697
PROPOSED SENATE COMMITTEE SUBSTITUTE H697-CSSQ-13 [v.1]

4/10/2007 3:36:25 PM

Short Title: Clarify Authority of Social Services Comm.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE SOCIAL SERVICES COMMISSION TO ADOPT RULES ESTABLISHING EDUCATIONAL REQUIREMENTS FOR STAFF EMPLOYED BY MATERNITY HOMES, CHILD PLACING AGENCIES, AND RESIDENTIAL CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

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

"(a) The Department of Health and Human Services shall inspect and license all maternity homes established in the State under ~~such~~ rules ~~and regulations~~ adopted by ~~as~~ the Social Services ~~Commission may adopt.~~Commission. The Commission shall adopt rules establishing educational requirements for executive directors and staff employed in maternity homes."

SECTION 2. G.S. 131D-10.5 is amended by adding a new subdivision to read:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

...

(7) Adopt rules establishing educational requirements for executive directors and staff employed by child placing agencies and residential child care facilities."

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

HOUSE BILL 697:
Clarify Authority of Social Services Comm.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 9, 2007
Introduced by:	Reps. Glazier, Goodwin, Barnhart, Parmon	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: ***House Bill 697 directs the Social Services Commission to adopt rules establishing educational requirements for executive directors and staff of maternity homes, child placing agencies, and residential child care facilities.***

CURRENT LAW: The Department of Health and Human Services (DHHS) inspects and licenses all maternity homes in the State under the rules and regulations adopted by the Social Services Commission (Commission).[1]

G.S. 131D-10.5 establishes the powers and duties of the Commission with regard to child placement and child care. It includes rule-making authority to:

- Implement the provisions and purposes of the Article controlling child placing and child care consistent with State and federal law.
- Govern appeals regarding licenses for child placement and child care.
- Document use of physical restraint in residential child-care facilities, and establish personnel and training requirements related to use of physical restraint and time out for staff employed in those facilities.

G.S. 131D-10.5 also provides the Commission the authority to issue declaratory rulings and adopt criteria for waivers of licensing rules.

EFFECTIVE DATE: The bill would become effective when it becomes law.

Kara McCraw, counsel to House Ways and Means, substantially contributed to this summary.

H0697e1-SMSQ

[1] G.S. 131D-1

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 720

Committee Substitute Favorable 3/21/07

Short Title: Name Change/Div. Faci. Svces/Commn. Hlth Svce. (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO CHANGE THE NAME OF THE DIVISION OF FACILITY SERVICES AND THE COMMISSION FOR HEALTH SERVICES TO BETTER REFLECT THE FUNCTIONS AND DUTIES PERFORMED BY THE DIVISION AND THE COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. In order to better reflect the functions and duties performed by the Division of Facility Services of the Department of Health and Human Services, the Division of Facility Services is renamed the Division of Health Service Regulation. Wherever the name "Division of Facility Services" appears in the General Statutes, the Revisor of Statutes shall replace "Division of Facility Services" with "Division of Health Service Regulation."

SECTION 2. In order to better reflect the functions and duties performed by the Commission for Health Services of the Department of Health and Human Services, the Commission for Health Services is renamed the Commission for Public Health. Wherever the name "Commission for Health Services" appears in the General Statutes, the Revisor of Statutes shall replace "Commission for Health Services" with "Commission for Public Health."

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

HOUSE BILL 720:
Name Change/Div. Faci. Svces/Commn. Hlth Svce

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 9, 2007
Introduced by:	Reps. Earle, Lucas	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 720 would change the name of the "Division of Facility Services" to the "Division of Health Service Regulation" and changes the name of the "Commission for Health Services" to the "Commission for Public Health".

The bill is effective when it becomes law.

BACKGROUND:

The Division of Facility Services (Division) operates in the Department of Health and Human Services. The function of the Division is to regulate medical, mental and group care facilities, emergency medical services, and local jails and to ensure the care in these facilities is adequate and safe. Through its Certificate of Need Section, the Division is responsible for the rational allocation of health services and facilities based on geographic, demographic and economic considerations.

The Commission for Health Services (Commission) operates in the Office of the State Health Director. The Commission adopts rules to protect and promote public health and to implement public health programs administered by the Department of Health and Human Services.

BILL ANALYSIS:

House Bill 720 renames the Division of Facility Services as the Division of Health Service Regulation and renames the Commission for Health Services as the Commission for Public Health. It also directs the Revisor of Statutes to replace the terms appropriately in the North Carolina General Statutes.

EFFECTIVE DATE: This act is effective when it becomes law.

H0720e2-SMSQ

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE APRIL 11, 2007

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ashley Campbell	Raysdale Leggett
Nancy Nesbit	Payne & Pruitt
J. Craig Jones	UHS
Curtis Gray	Staff
Bill Rose	Raysdale Leggett
ANN LOVE	DUKE U
Amy McConkey	Smith Anderson

VISITOR REGISTRATION SHEET

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

APRIL 11, 2007 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom Bacon	NC AHEC, CHAPEL HILL
Tommy Suter	Wyeth
Alex Goldstein	NC MHA
[illegible]	[illegible]
Bob Fryer	DHHS/DFS
Christine Wunsche	IOG - Daily Bulletin
Evelyn Hawthorne	OSBR.
Chip Baggett	NCMS
Cathy Wright	NCMS
Steve Keene	✓
Roger Bone	Bone Assoc

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE APRIL 11, 2007

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Fleming	BCBSNC
John McKay	GOV OFFICE
W R Mellen	NCGA
Stacy Flannery	NCMCFA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — APRIL 11, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	JD, AL, PA
Dennis Patterson	OSC
+ Pinsley	NCMSA
Gay Bowman	NC MSA
Ann Faris	NCMS Alliance Winston-Salem, NC
Julia Leggett	ADA-CIL
Jane Smith	DHHS
[signature]	NC Council
Daniel Baum	Kennedy Covington
Joel Maynard	Ch Patton Boggs & Blow.
Cliff Va	Gov. office

Senate Health Care Committee
Wednesday, April 18, 2007, 11:00 AM
Room 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 583	Public Health Technical Changes.-AB	Senator Purcell
SB 918	Amend MH/DD/SA Statutes/Rename Facilities.-AB	Senator Nesbitt, Jr.
SB 982	Immunization Certificate/College Students.	Senator Purcell
SB 1337	Amend Dental Hygiene Act.	Senator Purcell
SB 1428	Modify Involuntary Commitment Law/LME Control.	Senator Atwater

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, April 18, 2007 At 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 18, 2007, in Room 544 of the Legislative Office Building, with nineteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages. Several physicians were recognized attending the meeting. Dr. Darlyne Menscer, President of the NC Medical Society, Dr. Jim McDeavitt, Dr. Michael Thomason, Dr. Scott Furney, and also Dr. John Butts, Chief Medical Examiner, Division of Public Health.

Senator Bingham asked for a motion to adopt the PCS for SB 583, ***Public Health Technical Changes.-AB***, for discussion. Senator Dannelly made the motion, which passed. Senator Dr. Purcell was recognized to explain the bill. Sen. Purcell told the committee that SB 583 was requested by the State Health Director, Dr. Leah Devlin. Section one indicated the term "Department" meant Department of Environment and Natural Resources (DENR) and the term "Secretary" meant Secretary of Environment and Natural Resources. Section two provided that annual immunization reports would be filed by the school to the Department of Health and Human Services (DHHS) by November 1 of each year, which would help the year-round schools. Section three directed the DENR to establish within the Division of Public Health a comprehensive statewide injury prevention program. Section four authorized, in the event that no licensed physician accepts appointment, the Chief Medical Examiner to appoint as acting county medical examiner a licensed physician assistant, a nurse, a coroner, or an individual who has taken an approved course of training. Section five required each county to provide an appropriate facility for the examination and storage of bodies under the jurisdiction of the Chief Medical Examiner. Sen. Dr. Forrester asked how many counties do not have a county medical examiner and would have to substitute. Dr. John Butts, the state Chief Medical Examiner, stated that NC had Medical Examiners in every county, however some are not physicians. The law had always allowed appointments of another individual as a medical examiner. This law just clarifies the language. Senator Dannelly moved for a favorable report. The motion carried.

Senator Bingham stated that SB 918, ***Amend MH/DD/SA Statutes/Rename Facilities.-AB***. would not be heard at Senator Nesbitt's request.

Senator Bingham called for a motion for the adoption of the Proposed Committee Substitute for SB 982, ***Immunization Certificate/College Students***. Senator Dannelly moved to hear the PCS. Sen. Purcell was recognized to explain the bill, which had an amendment. Shawn Parker, Research Staff, explained the amendment. He stated that line eighteen inserted the words, "during the day", which addressed the changes being made in line 14 – 16, the four credit hours during the day. Senator Bingham asked Sen. Purcell to explain the bill. Sen. Purcell stated if you attend Community Colleges since

you do not live in dormitories you do not have to have any immunization record proof to attend Community Colleges. Also, adult students attending colleges usually do not live in residence halls on campus and often attend evening and weekend programs designed specifically for adults who are working while attending college. Currently the student taking one class during the day cannot take any other classes at night or on weekends without producing an immunization record. This bill will allow you to take one daytime course and then you also could take night and weekend classes. There are no objections to the bill. Senator Bingham asked to do a bit of housekeeping to the bill, stating there was no PCS it was an amendment. Sen. Bingham asked to take a vote on the amendment that was just explained. The motion carried. Senator Dorsett moved for a favorable report on the bill as amended. Senator Allran asked if this was enforced. Hope Williams, NC Independent Colleges and Universities, stated that the exemptions currently apply to any students taking night, weekend, or off campus courses. The exemption also applies if you are only taking one course during the day, but if you add a class at night or the weekend they need the immunization records. This is currently enforced if someone attended at both times. The public health concern is when they live in close quarters. Sen. Bingham noted that they already have a motion to adopt the bill as amended, to be rolled into a new PCS, unfavorable to the original bill. The motion carried.

Senator Bingham asked for a motion to adopt the Proposed Committee Substitute for SB 1337, ***Amend Dental Hygiene Act***. Senator Dannelly made the motion, which carried. Senator Dr. Purcell was recognized to present the bill. Sen. Purcell stated that SB 1337 would allow hygienists with additional education and experience to perform dental hygiene services on patients without a dentist being physically present in the office or at the location where the services were being performed. The dentist must still employ the hygienist; this bill does not allow for independent practice by hygienist. SB 1337 basically extends the law for public health hygienist, who already practices outside the direct supervision of a dentist, to the dental hygienist in private practices. NC currently has a state dentist who has hygienists that work under him, but can perform their services without the dentist being physically present. The bill creates a category of licensed supervision hygienist who must have three years of experience in clinical dental hygiene or a minimum of 2,000 hours of work as a hygienist, have an annual CPR certification, and have completed six hours of continuing education in medical emergencies each year. The goal of this bill is to increase the availability of preventive services in hospital, prisons, nursing homes, schools, and other underserved locations. The provisions in the bill are voluntary; the dentist will not be required to allow the hygienist he has employed to practice without supervision. Senator Dr. Forrester asked to state the difference in the PCS and original bill. Shawn Parker, Research Staff, stated it did remove the language codifying the procedures to be preformed by limited supervision hygienists and clarifies language from without supervision to without a licensed dentist being physically present. Senator Dorsett asked if hygienists could seek insurance pay. Senator Dr. Purcell stated the hygienists are employed and paid by the dentist. Senator Rand questioned this being done in a public health setting and stated concerns that the Licensing Board would have to set up for a new class of hygienists, the limited supervision. Sen. Rand asked if they

have to be certified, asking how anyone would know when one is or one is not. Shawn Parker, Research Staff, stated they are not looking for a separate licensure category and that if they met the designation the Doctor would be authorized to do it. Sen. Rand was concerned that no one would know this but the Doctor for whom they work. Sen. Rand asked, under the current law for public health people, if they could do just however they wanted to, under the supervision of the dentist. Senator Dr. Purcell stated they could only do the things that dental hygienist were allowed to do and were authorized by the state public health dentist. Sen. Rand asked the number of public health dentists in the state. Martha Taylor, DHHS Oral Health Section, here today taking annual leave to represent the NC Dental Hygiene Association, said the state oral health section employs fifty-two hygienists, but not all of them qualify to work under direction. Currently there are five public health dentists that work with hygienists. Senator Rand asked how many people they would treat in a year. Ms. Taylor stated she did not have a figure for that. Senator Rand moved that the committee set this off for two weeks and tell the parties involved to resolve it. There were many questions from committee members, which Senator Bingham accepted and discussed. The meeting closed with SB 1337 to be voted on in two weeks.

The meeting adjourned at 12:05 P.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, April 18, 2007

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

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

S.B. **583** Public Health Technical Changes.-AB

Draft Number:	PCS55402
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

Thursday, April 19, 2007

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

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

S.B. **982** Immunization Certificate/College Students.

Draft Number:	PCS75389
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 583*

Short Title: Public Health Technical Changes.-AB (Public)

Sponsors: Senator Purcell.

Referred to: Health Care.

March 12, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND OTHER CHANGES IN THE PUBLIC HEALTH LAW RELATED TO THE MEDICAL EXAMINER SYSTEM, INJURY CONTROL EFFORTS, TIMELINESS OF REPORTS BY SCHOOLS REGARDING IMMUNIZATIONS, AND THE CREATION, EXTENSION, AND DISSOLUTION OF SANITARY DISTRICTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-47 reads as rewritten:

"**§ 130A-47. Creation by Commission.**

(a) For the purpose of preserving and promoting the public health and welfare, the Commission may create sanitary districts without regard for county, township or municipal lines. However, no municipal corporation or any part of the territory in a municipal corporation shall be included in a sanitary district except at the request of the governing board of the municipal corporation. If the municipal corporation has not levied any tax nor performed any official act nor held any elections within a period of four years preceding the date of the petition for the sanitary district, a request of the governing board shall not be required.

(b) For the purposes of this Part, the term 'Department' means the Department of Environment and Natural Resources, and the term 'Secretary' means the Secretary of Environment and Natural Resources."

SECTION 2. G.S. 130A-155(c) reads as rewritten:

"(c) ~~Within 60 calendar days after the commencement of a new school year, the~~ The school shall file an annual immunization report with the ~~Department.~~Department by November 1. The child care facility shall file an immunization report annually with the Department. The report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the number of children who received a medical exemption and the number of children who received a religious exemption."

SECTION 3. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 6. Injury Prevention.

"**§ 130A-224. Department to establish program.**

(a) To protect and enhance the public health, welfare, and safety, the Department shall establish and administer a comprehensive statewide injury prevention program. The Department shall designate the Division of Public Health as the lead agency for injury prevention activities. The Division of Public Health shall:

(1) Develop a comprehensive State plan for injury prevention;

(2) Maintain an injury prevention program that includes data collection, surveillance, and education and promotes injury control activities; and

(3) Develop collaborative relationships with other State agencies and private and community organizations to establish programs promoting injury prevention.

(b) The Commission for Health Services may adopt rules necessary to implement a statewide injury prevention program."

SECTION 4. G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; vacancies.**

One or more county medical examiners for each county shall be appointed by the Chief Medical Examiner for a three-year term. County medical examiners shall be appointed from a list of physicians licensed to practice medicine in this State submitted by the medical society of the county in which the appointment is to be made. If no names are submitted by the society, the Chief Medical Examiner shall appoint one or more medical examiners from physicians in the county licensed to practice medicine in this State. In the event no licensed physician in a county accepts an appointment, the Chief Medical Examiner may appoint as acting county medical examiner one or more physicians licensed to practice medicine in this State from other ~~counties or the local registrar, deputy registrar, subregistrar or coroner.~~counties, a licensed physician assistant, a nurse, a coroner, or an individual who has taken an approved course of training as required by the Chief Medical Examiner. ~~In the event a medical examiner is unable to serve in a particular case or for a temporary period of time, the Chief Medical Examiner shall designate a physician licensed to practice medicine in this State, the local registrar, deputy registrar, subregistrar or coroner~~ The acting county medical examiner shall have all the duties and authority of the physician medical examiner except to perform autopsies. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so."

SECTION 5. G.S. 130A-381 reads as rewritten:

"**§ 130A-381. Additional services and facilities.**

In order to provide proper facilities for investigating deaths as authorized in this Part, the Chief Medical Examiner may arrange for the use of existing public or private laboratory facilities. Each county shall provide or contract for an appropriate facility for the examination and storage of bodies under Medical Examiner jurisdiction. The Chief

Medical Examiner may contract with qualified persons to perform or to provide support services for autopsies and other studies and investigations."

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 583*
PROPOSED COMMITTEE SUBSTITUTE S583-PCS55402-LN-11

Short Title: Public Health Technical Changes.-AB (Public)

Sponsors:

Referred to:

March 12, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND OTHER CHANGES IN THE PUBLIC HEALTH LAW RELATED TO THE MEDICAL EXAMINER SYSTEM, INJURY CONTROL EFFORTS, TIMELINESS OF REPORTS BY SCHOOLS REGARDING IMMUNIZATIONS, AND THE CREATION, EXTENSION, AND DISSOLUTION OF SANITARY DISTRICTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-47 reads as rewritten:

"**§ 130A-47. Creation by Commission.**

(a) For the purpose of preserving and promoting the public health and welfare, the Commission may create sanitary districts without regard for county, township or municipal lines. However, no municipal corporation or any part of the territory in a municipal corporation shall be included in a sanitary district except at the request of the governing board of the municipal corporation. If the municipal corporation has not levied any tax nor performed any official act nor held any elections within a period of four years preceding the date of the petition for the sanitary district, a request of the governing board shall not be required.

(b) For the purposes of this Part, the term 'Department' means the Department of Environment and Natural Resources, and the term 'Secretary' means the Secretary of Environment and Natural Resources."

SECTION 2. G.S. 130A-155(c) reads as rewritten:

"(c) ~~Within 60 calendar days after the commencement of a new school year, the~~ The school shall file an annual immunization report with the ~~Department.~~Department by November 1. The child care facility shall file an immunization report annually with the Department. The report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the

number of children who received a medical exemption and the number of children who received a religious exemption."

SECTION 3. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 6. Injury Prevention.

"**§ 130A-224. Department to establish program.**

To protect and enhance the public health, welfare, and safety, the Department shall establish and administer a comprehensive statewide injury prevention program. The Department shall designate the Division of Public Health as the lead agency for injury prevention activities. The Division of Public Health shall:

(1) Develop a comprehensive State plan for injury prevention;

(2) Maintain an injury prevention program that includes data collection, surveillance, and education and promotes injury control activities; and

(3) Develop collaborative relationships with other State agencies and private and community organizations to establish programs promoting injury prevention."

SECTION 4. G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; vacancies.**

One or more county medical examiners for each county shall be appointed by the Chief Medical Examiner for a three-year term. County medical examiners shall be appointed from a list of physicians licensed to practice medicine in this State submitted by the medical society of the county in which the appointment is to be made. If no names are submitted by the society, the Chief Medical Examiner shall appoint one or more medical examiners from physicians in the county licensed to practice medicine in this State. In the event no licensed physician in a county accepts an appointment, the Chief Medical Examiner may appoint as acting county medical examiner one or more physicians licensed to practice medicine in this State from other ~~counties or the local registrar, deputy registrar, subregistrar or coroner.~~counties, a licensed physician assistant, a nurse, a coroner, or an individual who has taken an approved course of training as required by the Chief Medical Examiner. ~~In the event a medical examiner is unable to serve in a particular case or for a temporary period of time, the Chief Medical Examiner shall designate a physician licensed to practice medicine in this State, the local registrar, deputy registrar, subregistrar or coroner~~ The acting county medical examiner shall have all the duties and authority of the physician medical examiner except to perform autopsies. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so."

SECTION 5. G.S. 130A-381 reads as rewritten:

"**§ 130A-381. Additional services and facilities.**

In order to provide proper facilities for investigating deaths as authorized in this Part, the Chief Medical Examiner may arrange for the use of existing public or private laboratory facilities. Each county shall provide or contract for an appropriate facility for the examination and storage of bodies under Medical Examiner jurisdiction. The Chief

Medical Examiner may contract with qualified persons to perform or to provide support services for autopsies and other studies and investigations."

SECTION 6. This act is effective when it becomes law.

SENATE BILL 583:
Public Health Technical Changes.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 17, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S583-CSLN-11		Legislative Analyst

SUMMARY: Senate Bill 583 would make the following changes to Chapter 130A, Public Health:

Section 1 indicates the term "Department" means Department of Environment and Natural Resources (DENR) and the term "Secretary" means Secretary of Environment and Natural Resources in Part 2 of Article 2 of Chapter 130A. Part 2 relates to Sanitary Districts and the additional language does not alter the current interpretation or application of the Part.

Section 2 provides that annual immunization reports must be filed by the school to the Department of Health and Human Services by November 1 of each year. *Currently the reports are due within 60 calendar days after commencement of a new school year.*

Section 3 directs the DENR to establish within the Division of Public Health a comprehensive statewide injury prevention program. The bill creates Part 6 within Article 7, Chronic Diseases, of Chapter 130A. *There are five other programs established within this Article: Part 1. Cancer; Part 2. Chronic Renal Disease; Part 3. Glaucoma and Diabetes; Part 4. Arthritis; and Part 5. Adult Health.*

The Proposed Committee Substitute removes language allowing the Commission for Health Services to adopt rules to implement this section.

Section 4 authorizes, in the event that no licensed physician accepts appointment, the Chief Medical Examiner to appoint as acting county medical examiner a licensed physician assistant, a nurse, a coroner, or an individual who has taken an approved course of training. The acting county medical examiner would have all the duties and authority of the physician medical examiner, but would not be authorized to perform autopsies.

Currently if no licensed physician in a county accepts an appointment, the Chief Medical Examiner may appoint on or more physicians licensed to practice medicine in this State from other counties or the local registrar, deputy registrar, subregistrar or coroner.

Section 5 requires each county to provide an appropriate facility for the examination and storage of bodies under the jurisdiction of the Chief Medical Examiner.

EFFECTIVE DATE: This act is effective when it becomes law.

S0583e1-SMSQ-CSLN-11

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 583*
PROPOSED COMMITTEE SUBSTITUTE S583-PCS55402-LN-11

Short Title: Public Health Technical Changes.-AB (Public)

Sponsors:

Referred to:

March 12, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND OTHER CHANGES IN THE PUBLIC HEALTH LAW RELATED TO THE MEDICAL EXAMINER SYSTEM, INJURY CONTROL EFFORTS, TIMELINESS OF REPORTS BY SCHOOLS REGARDING IMMUNIZATIONS, AND THE CREATION, EXTENSION, AND DISSOLUTION OF SANITARY DISTRICTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-47 reads as rewritten:

"**§ 130A-47. Creation by Commission.**

(a) For the purpose of preserving and promoting the public health and welfare, the Commission may create sanitary districts without regard for county, township or municipal lines. However, no municipal corporation or any part of the territory in a municipal corporation shall be included in a sanitary district except at the request of the governing board of the municipal corporation. If the municipal corporation has not levied any tax nor performed any official act nor held any elections within a period of four years preceding the date of the petition for the sanitary district, a request of the governing board shall not be required.

(b) For the purposes of this Part, the term 'Department' means the Department of Environment and Natural Resources, and the term 'Secretary' means the Secretary of Environment and Natural Resources."

SECTION 2. G.S. 130A-155(c) reads as rewritten:

"(c) ~~Within 60 calendar days after the commencement of a new school year, the~~ The school shall file an annual immunization report with the ~~Department.~~Department by November 1. The child care facility shall file an immunization report annually with the Department. The report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the

number of children who received a medical exemption and the number of children who received a religious exemption."

SECTION 3. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 6. Injury Prevention.

"**§ 130A-224. Department to establish program.**

To protect and enhance the public health, welfare, and safety, the Department shall establish and administer a comprehensive statewide injury prevention program. The Department shall designate the Division of Public Health as the lead agency for injury prevention activities. The Division of Public Health shall:

(1) Develop a comprehensive State plan for injury prevention;

(2) Maintain an injury prevention program that includes data collection, surveillance, and education and promotes injury control activities; and

(3) Develop collaborative relationships with other State agencies and private and community organizations to establish programs promoting injury prevention."

SECTION 4. G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; vacancies.**

One or more county medical examiners for each county shall be appointed by the Chief Medical Examiner for a three-year term. County medical examiners shall be appointed from a list of physicians licensed to practice medicine in this State submitted by the medical society of the county in which the appointment is to be made. If no names are submitted by the society, the Chief Medical Examiner shall appoint one or more medical examiners from physicians in the county licensed to practice medicine in this State. In the event no licensed physician in a county accepts an appointment, the Chief Medical Examiner may appoint as acting county medical examiner one or more physicians licensed to practice medicine in this State from other ~~counties or the local registrar, deputy registrar, subregistrar or coroner.~~counties, a licensed physician assistant, a nurse, a coroner, or an individual who has taken an approved course of training as required by the Chief Medical Examiner. ~~In the event a medical examiner is unable to serve in a particular case or for a temporary period of time, the Chief Medical Examiner shall designate a physician licensed to practice medicine in this State, the local registrar, deputy registrar, subregistrar or coroner~~ The acting county medical examiner shall have all the duties and authority of the physician medical examiner except to perform autopsies. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so."

SECTION 5. G.S. 130A-381 reads as rewritten:

"**§ 130A-381. Additional services and facilities.**

In order to provide proper facilities for investigating deaths as authorized in this Part, the Chief Medical Examiner may arrange for the use of existing public or private laboratory facilities. Each county shall provide or contract for an appropriate facility for the examination and storage of bodies under Medical Examiner jurisdiction. The Chief

Medical Examiner may contract with qualified persons to perform or to provide support services for autopsies and other studies and investigations."

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 918*

Short Title:	Amend MH/DD/SA Statutes/Rename Facilities.-AB	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:	Health Care.	

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES STATUTES AND TO RENAME MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 122C-3 is amended by adding the following new subdivisions to read:

"(13e) 'Eligible clinical social worker.' – A licensed Clinical Social Worker who is licensed by the North Carolina Social Work Certification and Licensure Board and has successfully completed a training course and passed an examination pertaining to the first level commitment examinations described in G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283. The Secretary of Health and Human Services shall adopt rules pertaining to a uniform training curriculum and examination. The eligible clinical social worker must have 24-hour access to supervision from a physician or eligible psychologist and must consult with and document the receipt of approval of the physician or eligible psychologist prior to releasing an individual from a commitment petition. This consultation may be via voice, video, or face to face.

(13f) 'Eligible psychiatric nurse.' – A Psychiatric-Mental Health Clinical Nurse Specialist in Advanced Practice or a Psychiatric-Mental Health Nurse Practitioner who is licensed by the North Carolina Board of Nursing and has successfully completed a training course and passed an examination pertaining to the first level commitment examinations described in G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283. The Secretary of Health and Human Services shall adopt rules pertaining to a uniform training

curriculum and examination. The eligible psychiatric nurse must have 24-hour access to supervision from a physician or eligible psychologist and must consult with and document the receipt of approval of the physician or eligible psychologist prior to releasing an individual from a commitment petition. This consultation may be via voice, video, or face to face.

(13g) 'Eligible clinical addictions specialist.' – A masters level Licensed Clinical Addictions Specialist who is licensed as such by the North Carolina Substance Abuse Professional Practice Board and has successfully completed a training course and passed an examination pertaining to the first level commitment examinations described in G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283. The Secretary of Health and Human Services shall adopt rules pertaining to a uniform training curriculum and examination. The eligible clinical addictions specialist must have 24-hour access to supervision from a physician or eligible psychologist and must consult with and document receipt of approval of the physician or eligible psychologist prior to releasing an individual from a commitment petition. This consultation may be via voice, video, or face to face."

SECTION 1.(b) G.S. 122C-112.1 is amended by adding the following new subdivisions to read:

"(34) Develop and adopt rules to implement a standardized statewide fee schedule and sliding fee scale policy for implementation by LMEs and providers.

(35) Adopt rules to standardize processes of mental health, developmental disabilities, and substance abuse services providers and ensure that LMEs monitor and provide technical assistance to providers in accordance with these rules."

SECTION 2. G.S. 122C-146 reads as rewritten:

"**§ 122C-146. Fee for service.**

The area authority and its contractual agencies shall ~~prepare fee schedules~~ implement the standardized fee schedule and sliding fee scale policy developed by the Secretary for services and shall make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party payment, except that individuals may not be charged for free services, as required in "The Amendments to the Education of the Handicapped Act", P.L. 99-457, provided to eligible infants and toddlers and their families. This exemption from charges does not exempt insurers or other third-party payors from being charged for payment for these services, if the person who is legally responsible for any eligible infant or toddler is first advised that the person may or may not grant permission for the insurer or other payor to be billed for the free services. However, no individual may be refused services because of an inability to pay. All funds collected from fees from area authority operated services shall be used for the

fiscal operation or capital improvements of the area authority's programs. The collection of fees by an area authority may not be used as justification for reduction or replacement of the budgeted commitment of local tax revenue. All funds collected from fees by contractual provider agencies shall be used to provide services to target population consumers."

SECTION 3. G.S. 122C-181(a) reads as rewritten:

"(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) ~~For the mentally ill:~~Psychiatric Hospitals:
- a. Cherry Hospital;
- ~~b. Dorothea Dix Hospital;~~
- ~~c. John Umstead Hospital; and~~
- a1. Central Regional Hospital; and
- ~~d. Broughton Hospital; and~~
- b1. Broughton Hospital.

(2) ~~For the mentally retarded:~~Developmental Centers:
- a. Caswell Developmental Center;
- ~~b. O'Berry Center;~~
- c. Murdoch Developmental Center; and
- c1. J. Iverson Riddle Developmental Center.
- ~~d. Western Carolina Center; and~~
- ~~e. Black Mountain Center; and~~

(3) ~~For substance abusers:~~Alcohol and Drug Treatment Centers:
- a. Walter B. Jones Alcohol and Drug Abuse Treatment ~~Center at Greenville;~~Center;
- ~~b. Alcohol and Drug Abuse Treatment Center at John Umstead Hospital; and~~
- b1. R.J. Blackley Alcohol and Drug Abuse Treatment Center; and
- c. Julian F. Keith Alcohol and Drug Abuse Treatment ~~Center; and~~ Center.

(4) ~~As special care facilities:~~Neuro-Medical Treatment Centers:
- ~~a. North Carolina Special Care Center;~~
- ~~b. Whitaker School; and~~
- ~~c. Wright School.~~
- a1. Wilson Neuro-Medical Treatment Center;
- b1. Black Mountain Neuro-Medical Treatment Center; and
- c1. O'Berry Neuro-Medical Treatment Center.

(5) Residential Programs for Children:
- a. Whitaker School; and
- b. Wright School."

SECTION 4.(a) G.S. 122C-205(d) reads as rewritten:

"**§ 122C-205. Return of clients to 24-hour facilities.**

...

(d) In the situations described in subsections (a) and (b) of this section, the responsible professional shall also notify or cause to be notified as soon as practicable:

(1) The next of kin of the client or legally responsible person for the client;

(2) The clerk of superior court of the county of commitment of the client;

(3) The area authority of the county of residence of the client, if appropriate;

(4) The ~~physician or eligible psychologist~~physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist who performed the first examination for a commitment of the client, if appropriate; and

(5) Any official who has placed a detainer on a client as described in subdivision (a)(5) of this section

of the escape or breach of condition of the client's release upon occurrence of either action and of his subsequent return to the facility."

SECTION 4.(b) G.S. 122C-261 reads as rewritten:

"**§ 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.**

(a) Anyone who has knowledge of an individual who is mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a clerk or assistant or deputy clerk of superior court or a magistrate and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist. The affidavit shall include the facts on which the affiant's opinion is based. If the affiant has knowledge or reasonably believes that the respondent, in addition to being mentally ill, is also mentally retarded, this fact shall be stated in the affidavit. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, the clerk or magistrate shall issue an order to a law enforcement officer or any other person authorized under G.S. 122C-251 to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist.

If the clerk or magistrate finds that, in addition to probably being mentally ill, the respondent is also probably mentally retarded, the clerk or magistrate shall contact the

area authority before issuing a custody order and the area authority shall designate the facility to which the respondent is to be taken for examination by a ~~physician or eligible psychologist.~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist. The clerk or magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent.

(c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) If the affiant is a ~~physician or eligible psychologist,~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit or a copy in paper form that is printed through the facsimile transmission of the affidavit. If the affidavit is filed through facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit. This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist recommends outpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transportation to or custody at a 24-hour facility described in G.S. 122C-252. However, if the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported. If a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions

specialist executes an affidavit for inpatient commitment of a respondent, a second physician shall be required to perform the examination required by G.S. 122C-266.

(e) Upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State.

(f) When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist as set forth in G.S. 122C-263 shall be carried out in accordance with the area plan. Prior to issuance of a custody order for a respondent who resides in an area authority with a single portal plan, the clerk or magistrate shall communicate with the area authority to determine the appropriate 24-hour facility to which the respondent should be admitted according to the area plan or to determine if there are more appropriate resources available through the area authority to assist the petitioner or the respondent. When an individual from a single portal area is presented for commitment at a 24-hour area or State facility directly, the individual may not be accepted for admission until the facility notifies the area authority and the area authority agrees to the admission. If the area authority does not agree to the admission, it shall determine the appropriate 24-hour facility to which the individual should be admitted according to the area plan or determine if there are more appropriate resources available through the area authority to assist the individual. If the area authority agrees to the admission, further planning of treatment for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.

Notwithstanding the provisions of this section, in no event shall an individual known or reasonably believed to be mentally retarded be admitted to a State psychiatric hospital, except as follows:

(1) Persons described in G.S. 122C-266(b);

(2) Persons admitted pursuant to G.S. 15A-1321;

(3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and

(4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(g) After July 1, 2007, the Local Management Entities involved in the First Level Commitment Pilot Program, as specified in S.L. 2003-178 will be able to continue operation under the guidelines of the Pilot until such time as administrative rules are adopted. The Secretary of Health and Human Services shall adopt rules pursuant to this section."

SECTION 4.(c) G.S. 122C-262(a), 122C-262(b), and 122C-262(c) read as rewritten:

"**§ 122C-262. Special emergency procedure for individuals needing immediate hospitalization.**

(a) Anyone, including a law enforcement officer, who has knowledge of an individual who is subject to inpatient commitment according to the criteria of G.S. 122C-261(a) and who requires immediate hospitalization to prevent harm to self or others, may transport the individual directly to an area facility or other place, including a State facility for the mentally ill, for examination by a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist in accordance with G.S. 122C-263(c).

(b) Upon examination by the ~~physician or eligible psychologist,~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist, if the individual meets the criteria required in G.S. 122C-261(a), the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall so certify in writing before any official authorized to administer oaths. The certificate shall also state the reason that the individual requires immediate hospitalization. If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist knows or has reason to believe that the individual is mentally retarded, the certificate shall so state.

(c) If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist executes the oath, appearance before a magistrate shall be waived. The ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall send a copy of the certificate to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours, excluding Saturday, Sunday, and holidays, of the time that it was signed, the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall also communicate the findings to the clerk by telephone.

..."

SECTION 4.(d) G.S. 122C-263 reads as rewritten:

"**§ 122C-263. Duties of law-enforcement officer; first examination by ~~physician or eligible psychologist.~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist.**

(a) Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility for examination by a ~~physician or eligible psychologist;~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist; if a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist is not available in the area facility, the person designated to provide transportation shall take the respondent to any ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist locally available. If a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist is not immediately available, the respondent may be temporarily detained in an area facility, if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the mentally ill, but not in a jail or other penal facility.

(b) The examination set forth in subsection (a) of this section is not required if:

(1) The affiant who obtained the custody order is a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist who recommends inpatient commitment;

(2) The custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and he was found incapable of proceeding; or

(3) Repealed by Session Laws 1987, c. 596, s. 3.

In any of these cases, the law-enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

(c) The ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. The examination shall include but is not limited to an assessment of the respondent's:

(1) Current and previous mental illness and mental retardation including, if available, previous treatment history;

(2) Dangerousness to self, as defined in G.S. 122C-3(11)a. or others, as defined in G.S. 122C-3(11)b.;

(3) Ability to survive safely without inpatient commitment, including the availability of supervision from family, friends or others; and

(4) Capacity to make an informed decision concerning treatment.

(d) After the conclusion of the examination the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall make the following determinations:

(1) If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist finds that:

a. The respondent is mentally ill;

b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or others;

c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and

d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist finds shall so show on the examination report and shall recommend outpatient commitment. In addition the examining ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall recommend inpatient commitment, shall show the name, address, and telephone number of the proposed outpatient treatment physician or center. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

(2) If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist finds that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall recommend inpatient commitment, and shall so show on the examination report. If, in

addition to mental illness and dangerousness, the physician or eligible psychologist also finds that the respondent is known or reasonably believed to be mentally retarded, this finding shall be shown on the report. The law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action.

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

a. Persons described in G.S. 122C-266(b);
b. Persons admitted pursuant to G.S. 15A-1321;
c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(3) If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the

respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody.

(e) The findings of the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist and the facts on which they are based shall be in writing in all cases. The ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall send a copy of the findings to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall also communicate his findings to the clerk by telephone.

(f) When outpatient commitment is recommended, the examining ~~physician or eligible psychologist,~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist, if different from the proposed outpatient treatment physician or center, shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time. The examining ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist before the appointment shall notify by telephone the designated outpatient treatment physician or center and shall send a copy of the notice and his examination report to the physician or center.

(g) The ~~physician or eligible psychologist,~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist, at the completion of the examination, shall provide the respondent with specific information regarding the next steps that will occur."

SECTION 4.(e) G.S. 122C-264(a), 122C-264(b), and 122C-264(b1) read as rewritten:

"**§ 122C-264. Duties of clerk of superior court and the district attorney.**

(a) Upon the clerk of superior court's receipt of a ~~physician's or eligible psychologist's~~finding by a physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist that the respondent meets the criteria of G.S. 122C-263(d)(1) and that outpatient commitment is recommended, the clerk of superior court of the county where the petition was initiated, upon direction of a district court judge, shall calendar the matter for hearing and shall notify the respondent, the proposed outpatient treatment physician or center, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.

(b) Upon receipt by the clerk of superior court of a ~~physician's or eligible psychologist's~~ finding by a physician, eligible psychologist, eligible clinical social

worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist that a respondent meets the criteria of G.S. 122C-263(d)(2) and that inpatient commitment is recommended, the clerk of superior court of the county where the 24-hour facility is located shall, after determination required by G.S. 122C-261(c) and upon direction of a district court judge, assign counsel if necessary, calendar the matter for hearing, and notify the respondent, his counsel, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.

(b1) Upon receipt by the clerk of superior court of a ~~physician's or eligible psychologist's~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist certificate that a respondent meets the criteria of G.S. 122C-261(a) and that immediate hospitalization is needed pursuant to G.S. 122C-262, the clerk of superior court of the county where the treatment facility is located shall submit the certificate to the Chief District Court Judge. The court shall review the certificate within 24 hours, excluding Saturday, Sunday, and holidays, for a finding of reasonable grounds in accordance with 122C-261(b). The clerk shall notify the treatment facility of the court's findings by telephone and shall proceed as set forth in subsections (b), (c), and (f) of this section.

..."

SECTION 4.(f) G.S. 122C-265(a) reads as rewritten:

"(a) If a respondent, who has been recommended for outpatient commitment by an examining ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist different from the proposed outpatient treatment physician or center, fails to appear for examination by the proposed outpatient treatment physician or center at the designated time, the physician or center shall notify the clerk of superior court who shall issue an order to a law-enforcement officer or other person authorized under G.S. 122C-251 to take the respondent into custody and take him immediately to the outpatient treatment physician or center for evaluation. The custody order is valid throughout the State. The law-enforcement officer may wait during the examination and return the respondent to his home after the examination."

SECTION 4.(g) G.S. 122C-266(e) reads as rewritten:

"(e) If the 24-hour facility described in G.S. 122C-252 or G.S. 122C-262 is the facility in which the first examination by a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist occurred and is the same facility in which the respondent is held, the second examination shall occur not later than the following regular working day."

SECTION 4.(h) G.S. 122C-273 (a)(2) reads as rewritten:

"(a) Unless prohibited by Chapter 90 of the General Statutes, if the commitment order directs outpatient treatment, the outpatient treatment physician may prescribe or administer, or the center may administer, to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards.

...

(2) If the respondent fails to comply, but does not clearly refuse to comply, with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance, the physician, the physician's designee, or the center may request the court to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk shall issue an order to a law-enforcement officer to take the respondent into custody and to take him immediately to the designated outpatient treatment physician or center for examination. The custody order is valid throughout the State. The law-enforcement officer shall turn the respondent over to the custody of the physician or center who shall conduct the examination and then release the respondent. The law-enforcement officer may wait during the examination and return the respondent to his home after the examination. An examination conducted under this subsection in which a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist determines that the respondent meets the criteria for inpatient commitment may be substituted for the first examination required by G.S. 122C-263 if the clerk or magistrate issues a custody order within six hours after the examination was performed."

SECTION 4.(i) G.S. 122C-281 reads as rewritten:

"**§ 122C-281. Affidavit and petition before clerk or magistrate; custody order.**

(a) Any individual who has knowledge of a substance abuser who is dangerous to himself or others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate, execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist.

The affidavit shall include the facts on which the affiant's opinion is based. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably a substance abuser and dangerous to himself or others, he shall issue an order to a law-enforcement officer or any other person authorized by G.S. 122C-251 to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist.

(c) If the clerk or magistrate issues a custody order, he shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) If the affiant is a ~~physician or eligible psychologist,~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist, he may execute the affidavit before any official authorized to administer oaths. He is not required to appear before the clerk or magistrate for this purpose. His examination shall comply with the requirements of the initial examination as provided in G.S. 122C-283(c). If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist recommends commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for commitment, he shall issue an order for transportation to or custody at a 24-hour facility or release the respondent, pending hearing, as described in G.S. 122C-283(d)(1). If a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist executes an affidavit for commitment of a respondent, a second qualified professional shall perform the examination required by G.S. 122C-285.

(e) Upon receipt of the custody order of the clerk or magistrate, a law-enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed. The custody order is valid throughout the State.

(f) When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist as set forth in G.S. 122C-283(c) shall be carried out in accordance with the area plan. When an individual from a single portal area is presented for commitment at a facility directly, he may be accepted for admission in accordance with G.S. 122C-285. The facility shall notify the area authority within 24 hours of admission and further planning of treatment for the individual is the joint responsibility of the area authority and the facility as prescribed in the area plan.

(g) After July 1, 2007, the Local Management Entities involved in the First Level Commitment Pilot Program, as specified in S.L. 2003-178, will be able to continue operation under the guidelines of the Pilot until such time as administrative rules are adopted. The Secretary of Health and Human Services shall adopt rules pursuant to this section."

SECTION 4.(j) G.S. 122C-282 reads as rewritten:

"**§ 122C-282. Special emergency procedure for violent individuals.**

When an individual subject to commitment under the provisions of this Part is also violent and requires restraint and when delay in taking him to a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist for examination would likely endanger life or property, a law-enforcement officer may take the person into custody and take him immediately before a magistrate or clerk. The law-enforcement officer shall execute the affidavit required by G.S. 122C-281 and in addition shall swear that the respondent is violent and requires restraint and that delay in

taking the respondent to a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist for an examination would endanger life or property.

If the clerk or magistrate finds by clear, cogent, and convincing evidence that the facts stated in the affidavit are true, that the respondent is in fact violent and requires restraint, and that delay in taking the respondent to a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist for an examination would endanger life or property, he shall order the law-enforcement officer to take the respondent directly to a 24-hour facility described in G.S. 122C-252.

Respondents received at a 24-hour facility under the provisions of this section shall be examined and processed thereafter in the same way as all other respondents under this Part."

SECTION 4.(k) G.S. 122C-283 reads as rewritten:

"**§ 122C-283. Duties of law-enforcement officer; first examination by ~~physician or eligible psychologist.~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist.**

(a) Without unnecessary delay after assuming custody, the law-enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility for examination by a ~~physician or eligible psychologist; if a physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist; if a physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist is not available in the area facility, he shall take the respondent to any ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist locally available. If a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist is not immediately available, the respondent may be temporarily detained in an area facility if one is available; if an area facility is not available, he may be detained under appropriate supervision, in his home, in a private hospital or a clinic, or in a general hospital, but not in a jail or other penal facility.

(b) The examination set forth in subsection (a) of this section is not required if:

(1) The affiant who obtained the custody order is a ~~physician or eligible psychologist;~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist; or

(2) The respondent is in custody under the special emergency procedure described in G.S. 122C-282.

In these cases when it is recommended that the respondent be detained in a 24-hour facility, the law-enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

(c) The ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. The examination shall include but is not limited to an assessment of the respondent's:

(1) Current and previous substance abuse including, if available, previous treatment history; and

(2) Dangerousness to himself or others as defined in G.S. 122C-3(11).

(d) After the conclusion of the examination the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist shall make the following determinations:

(1) If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist finds that the respondent is a substance abuser and is dangerous to himself or others, he shall recommend commitment and whether the respondent should be released or be held at a 24-hour facility pending hearing and shall so show on [the] his examination report. Based on the ~~physician's or eligible psychologist's recommendation~~recommendation of the physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist the law-enforcement officer or other designated individual shall take the respondent to a 24-hour facility described in G.S. 122C-252 or release the respondent.

(2) If the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist finds that the condition described in subdivision (1) of this subsection does not exist, the respondent shall be released and the proceedings terminated.

(e) The findings of the ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist and the facts on which they are based shall be in writing in all cases. A copy of the findings shall be sent to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the physician or eligible psychologist shall also communicate his findings to the clerk by telephone."

SECTION 4.(l) G.S. 122C-284(a) reads as rewritten:

"(a) Upon receipt by the clerk of superior court of the findings of a ~~physician's or eligible psychologist's finding~~ physician, eligible psychologist, eligible clinical social

worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist that a respondent is a substance abuser and dangerous to himself or others and that commitment is recommended, the clerk of superior court of the county where the facility is located, if the respondent is held in a 24-hour facility, or the clerk of superior court where the petition was initiated shall upon direction of a district court judge assign counsel, calendar the matter for hearing, and notify the respondent, his counsel, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court."

SECTION 4.(m) G.S. 122C-285(b) reads as rewritten:

"(b) If the 24-hour facility described in G.S. 122C-252 is the facility in which the first examination by a ~~physician or eligible psychologist~~ physician, eligible psychologist, eligible clinical social worker, eligible masters level psychiatric nurse, or eligible clinical addictions specialist occurred and is the same facility in which the respondent is held, the second examination must occur not later than the following regular working day."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 982

Short Title:	Immunization Certificate/College Students.	(Public)
Sponsors:	Senators Purcell; Atwater, Dorsett, Jones, Malone, and Rand.	
Referred to:	Health Care.	

March 20, 2007

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE REQUIREMENT FOR AN IMMUNIZATION CERTIFICATE FROM CERTAIN COLLEGE STUDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-155.1 reads as rewritten:

"(a) Except as otherwise provided in this subsection, no person shall attend a college or university, whether public, private, or religious, unless a certificate of immunization or a record of immunization from a high school located in North Carolina indicating that the person has received immunizations required by G.S. 130A-152 is presented to the college or university. This section shall not apply to educational institutions established under Chapter 115D of the General Statutes, or to students registering only in off-campus courses, or to students attending night or weekend classes only, or to students taking a course load of four credit hours or less and residing off ~~campus.~~campus, or to students taking a combination of night or weekend courses and no more than four credit hours during the day and residing off campus. The person shall present a certificate or record of immunization on or before the date the person first registers for a quarter or semester during which the student will reside on the campus or first registers for more than four credit hours to the registrar of the college or university. If a certificate or record of immunization is not in the possession of the college or university on the date of first registration, the college or university shall present a notice of deficiency to the person. The person shall have 30 calendar days from the date of the person's first registration to obtain the required immunization. If immunization requires a series of doses and the period necessary to give the vaccine at standard intervals extends beyond the date of the first registration, the student shall be allowed to attend the college or university upon written certification by a physician that the standard series is in progress. The physician shall state the time period needed to complete the series. Upon termination of this time period, the college or university shall not permit the person to continue in attendance unless the required immunization has been obtained.

(b) The college or university shall maintain on file immunization records for all persons attending the school which contain the information required for a certificate of immunization as specified in G.S. 130A-154. These certificates shall be open to inspection by the Department and the local health department during normal business hours. When a person transfers to another college or university, the college or university which the person previously attended shall, upon request, send a copy of the person's immunization record at no charge to the college or university to which the person has transferred.

(c) Within 60 calendar days after the commencement of a new school year, the college or university shall file an immunization report with the Department. The report shall be filed on forms prepared by the Department and shall state the number of persons attending the school or facility, the number of persons who had not obtained the required immunization within 30 days of their first attendance, the number of persons who received a medical exemption and the number of persons who received a religious exemption.

(d) Repealed by Session Laws 1999-110, s. 5."

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

SENATE BILL 982:
Immunization Certificate/College Students

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 17, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 982 provides that students would not be required to provide documentation of immunizations in order to attend a college or university in North Carolina if the students reside off campus, take a combination of night or weekend courses and do not register for more than four credit hours during the day.

CURRENT LAW:

In order to attend a public, private, or religious college or university in North Carolina, a student must present to the college or university a certificate of immunization or a record of immunization from a North Carolina high school indicating the student has received immunizations required by G.S. 130A-152. This requirement does not apply to students attending community college or other institutions established under Chapter 115D.

The requirement also does not apply to students who reside off campus and:

- Register for off campus courses only,
- Attend night or weekend courses only, or
- Register for a course load of four credit hours or less.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

General Statute 130A-152 "Immunization required" provides that every child present in this State shall be immunized against **diphtheria, tetanus, whooping cough, poliomyelitis, red measles (rubeola) and rubella**. In addition, every child present in this State shall be immunized against any other disease upon a determination by the Commission for Health Services (Commission) that the immunization is in the interest of the public health.

The Commission is directed to adopt rules, to be enforced by the Department of Health and Human Services, concerning the implementation of the immunization program. Only those vaccines that meet the standards of the United States Food and Drug Administration and have been approved for use by the Commission may be used.

S0982e1-SMSQ

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 4-18-07

S. B. No. 982 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
Sen.)

1 moves to amend the bill on page 1, line 18
2 ( ) WHICH CHANGES THE TITLE
3 by inserting in between the ~~Words~~ "hours" and
4 "to" the phrase "during the day".
5
6
7
9
10
11
12
13
14
15
16
17
18
19

SIGNED William A Purcell

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 982
PROPOSED COMMITTEE SUBSTITUTE S982-PCS75389-SQ-20

Short Title: Immunization Certificate/College Students. (Public)

Sponsors:

Referred to:

March 20, 2007

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE REQUIREMENT FOR AN IMMUNIZATION CERTIFICATE FROM CERTAIN COLLEGE STUDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-155.1 reads as rewritten:

"(a) Except as otherwise provided in this subsection, no person shall attend a college or university, whether public, private, or religious, unless a certificate of immunization or a record of immunization from a high school located in North Carolina indicating that the person has received immunizations required by G.S. 130A-152 is presented to the college or university. This section shall not apply to educational institutions established under Chapter 115D of the General Statutes, or to students registering only in off-campus courses, or to students attending night or weekend classes only, or to students taking a course load of four credit hours or less and residing off ~~campus.~~campus, or to students taking a combination of night or weekend courses and no more than four credit hours during the day and residing off campus. The person shall present a certificate or record of immunization on or before the date the person first registers for a quarter or semester during which the student will reside on the campus or first registers for more than four credit ~~hours~~hours during the day to the registrar of the college or university. If a certificate or record of immunization is not in the possession of the college or university on the date of first registration, the college or university shall present a notice of deficiency to the person. The person shall have 30 calendar days from the date of the person's first registration to obtain the required immunization. If immunization requires a series of doses and the period necessary to give the vaccine at standard intervals extends beyond the date of the first registration, the student shall be allowed to attend the college or university upon written certification by a physician that the standard series is in progress. The physician shall state the time period needed to complete the series. Upon termination of this time period, the college

or university shall not permit the person to continue in attendance unless the required immunization has been obtained.

(b) The college or university shall maintain on file immunization records for all persons attending the school which contain the information required for a certificate of immunization as specified in G.S. 130A-154. These certificates shall be open to inspection by the Department and the local health department during normal business hours. When a person transfers to another college or university, the college or university which the person previously attended shall, upon request, send a copy of the person's immunization record at no charge to the college or university to which the person has transferred.

(c) Within 60 calendar days after the commencement of a new school year, the college or university shall file an immunization report with the Department. The report shall be filed on forms prepared by the Department and shall state the number of persons attending the school or facility, the number of persons who had not obtained the required immunization within 30 days of their first attendance, the number of persons who received a medical exemption and the number of persons who received a religious exemption.

(d) Repealed by Session Laws 1999-110, s. 5."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1337

Short Title:	Amend Dental Hygiene Act.	(Public)
Sponsors:	Senators Purcell; Dannelly and Malone.	
Referred to:	Health Care.	

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA DENTAL HYGIENE ACT TO PROVIDE FOR CERTAIN ACTIVITIES TO BE PERFORMED BY LICENSED HYGIENISTS WITH LIMITED SUPERVISION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(c1) "Limited supervision hygienist" as used in this Article shall mean a dental hygienist who meets the following requirements:

(1) Has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist.

(2) Has an annual CPR certification.

(3) Completes six hours each year of continuing education in medical emergencies.

(c2) "Limited supervision procedure" shall mean taking impressions for study models and opposing casts that are not used for construction of dental appliances, but

may be used for the fabrication of bleaching trays and occlusal guards; applying sealants to teeth that do not require mechanical alteration before the appliance of the sealants; cementing temporary restorations using temporary cement; applying acid etch materials and rinses; applying bonding agents; removing periodontal dressings; placing and removing temporary restorations; applying dentin desensitizing solutions; performing periodontal screening; performing periodontal probing; performing subgingival exploration for or removing hard and soft deposits; applying resorbable antibiotic agents prescribed by a dentist; performing radiographs; administering fluoride treatments; polishing teeth; and cleaning teeth, including cleaning with sonic and ultrasonic power instruments.

(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts and such acts are being performed pursuant to the dentist's order, control and approval."

SECTION 2. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) ~~A~~ Except as provided in subsection (a1) of this section, a dental hygienist may practice only under the supervision of one or more licensed dentists. This subsection shall be deemed to be complied with in the case of dental hygienists employed by or under contract with a local health department or State government dental public health program and especially trained by the Dental Health Section of the Department of Health and Human Services as public health hygienists, while performing their duties for the persons officially served by the local health department or State government program under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services.

(a1) A limited supervision hygienist may perform one or more limited supervision procedures without the supervision of a dentist if all of the following conditions are met:

(1) The limited supervision procedures delegated to the limited supervision hygienist are conducted pursuant to a written order from a licensed dentist.

(2) The limited supervision procedures are conducted within one year of the dentist's in-person evaluation of the patient, which evaluation shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, and a diagnosis of the patient's condition.

A dental hygienist shall not establish or operate a separate care facility that exclusively renders dental hygiene services or limited supervision procedures.

(b) A dentist in private practice may not employ more than two dental hygienists at one and the same time who are employed in clinical dental hygiene positions.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1337
PROPOSED COMMITTEE SUBSTITUTE S1337-CSSQ-19 [v.2]

4/17/2007 5:14:13 PM

Short Title: Amend Dental Hygiene Act. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA DENTAL HYGIENE ACT TO PROVIDE FOR CERTAIN ACTIVITIES TO BE PERFORMED BY LICENSED HYGIENISTS WITH LIMITED SUPERVISION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(c1) "Limited supervision hygienist" as used in this Article shall mean a dental hygienist who meets the following requirements:

(1) Has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist.

(2) Has an annual CPR certification.

(3) Completes six hours each year of continuing education in medical emergencies.

(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts and such acts are being performed pursuant to the dentist's order, control and approval."

SECTION 2. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) ~~A~~ Except as provided in subsection (a1) of this section, a dental hygienist may practice only under the supervision of one or more licensed dentists. This subsection shall be deemed to be complied with in the case of dental hygienists employed by or under contract with a local health department or State government dental public health program and especially trained by the Dental Health Section of the Department of Health and Human Services as public health hygienists, while performing their duties for the persons officially served by the local health department or State government program under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services.

(a1) A limited supervision hygienist may perform one or more dental hygiene functions as described in G.S. 90-221(a) without a licensed dentist being physically present if all of the following conditions are met:

(1) A licensed dentist directs in writing the limited supervision hygienist to perform the dental hygiene functions.

(2) The licensed dentist has personally conducted an evaluation of the patient not more than one year prior to issuing the written order to the limited supervision hygienist. This subdivision applies if the evaluation included a complete oral examination of the patient, a thorough analysis of the patient's health history, and a diagnosis of the patient's condition.

A dental hygienist shall not establish or operate a separate care facility that exclusively renders dental hygiene services.

(b) A dentist in private practice may not employ more than two dental hygienists at one and the same time who are employed in clinical dental hygiene positions.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

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

SENATE BILL 1337:
Amend Dental Hygiene Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 18, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S1337-CSSQ-19		Legislative Analyst

SUMMARY: Senate Bill 1337 would authorize a "limited supervision hygienist" to perform dental hygiene functions directed in writing by a licensed dentist without the dentist being physically present.

The Proposed Committee Substitute removes language codifying procedures performed by limited supervision hygienists and clarifies language in subsection (a1) from without supervision to without a licensed dentist being physically present.

CURRENT LAW:

A dental hygienist may practice only under the supervision of one or more licensed dentists.[1]

A dental hygienist may perform complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist[2] in a locale where a licensed dentist is physically present during the performance pursuant to the dentist's order, control, and approval.[3]

BILL ANALYSIS:

Senate Bill 1337 amends G.S. 90-221 to define a licensed supervision hygienist as a dental hygienist who:

- Has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing prophylaxis or periodontal debridement under the supervision of a licensed dentist,
- Has an annual CPR certification, and
- Completes six hours of continuing education in medical emergencies each year.

The bill authorizes a limited supervision hygienist to perform one or more dental hygiene functions without a licensed dentist being physically present if the dentist directs in writing the function to be performed within one year of completing an evaluation of the patient. The evaluation must include a complete oral examination, a thorough analysis of the patient's health history, and a diagnosis of the patient's condition.

The bill prohibits a dental hygienist from establishing or operating a separate care facility that exclusively renders dental hygiene services.

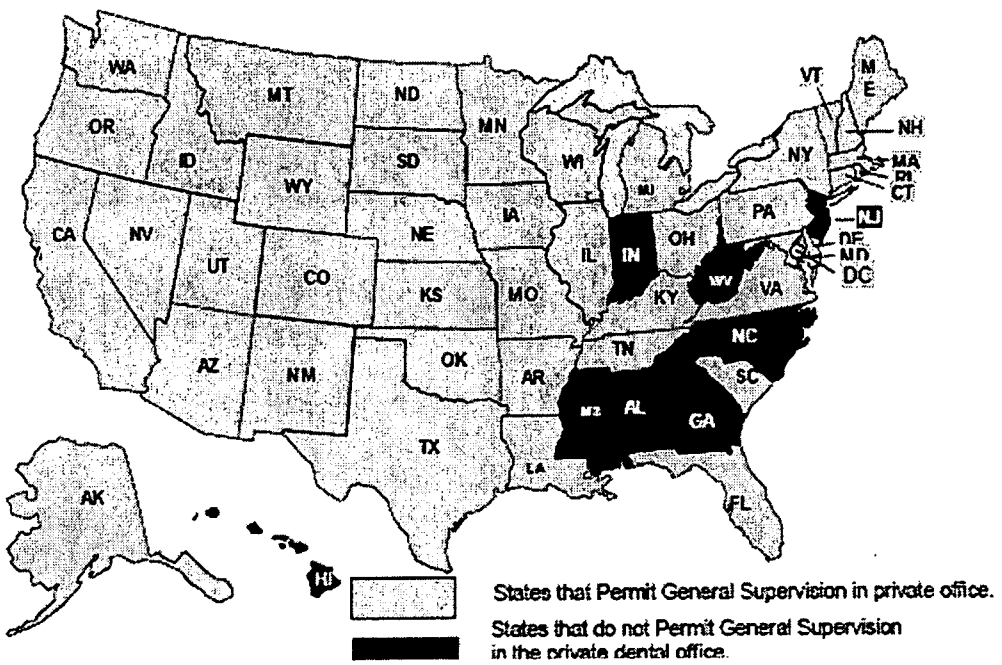
EFFECTIVE DATE: This act is effective when it becomes law.

---

[1] G.S. 90-233(a)
[2] G.S. 90-221(a)
[3] G.S. 90-221(f)

BACKGROUND:

States that Permit General Supervision in the Dental Office



Direct Supervision *means that a dentist must be present in the facility when a dental hygienist performs procedures.* ***General Supervision*** *means that a dentist has authorized a dental hygienist to perform procedures but need not be present in the treatment facility during the performance of those procedures.* ***November 7, 2006***
www.adha.org

S1337e1-SMSQ-CSSQ-17

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1428

Short Title: Modify Involuntary Commitment Law/LME Control. (Public)

Sponsors: Senator Atwater.

Referred to: Health Care.

March 26, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE MODIFICATIONS TO THE LAWS RELATED TO INVOLUNTARY COMMITMENTS IN ORDER TO GIVE LOCAL MANAGEMENT ENTITIES MORE CONTROL OVER STATE PSYCHIATRIC HOSPITAL UTILIZATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-263(a) reads as rewritten:

"(a) Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility for examination by a physician or eligible ~~psychologist; if~~ psychologist. If a physician or eligible psychologist is not available in the area facility, the person designated to provide transportation shall take the respondent to any physician or eligible psychologist locally available. If a physician or eligible psychologist is not immediately available, the respondent may be temporarily detained in an area ~~facility, if one is available; if~~ facility. If an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the ~~mentally ill, but not~~ mentally ill. In no event may a respondent be detained in a jail or other penal facility."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1428
PROPOSED COMMITTEE SUBSTITUTE S1428-CSRC-14 [v.2]

4/17/2007 10:30:19 PM

Short Title: Increase LME Control/State Psych. Hosp. Use. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY INCREASING LOCAL MANAGEMENT ENTITIES CONTROL OVER STATE PSYCHIATRIC HOSPITAL UTILIZATION.

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 plan for increasing local management entities (LMEs) responsibility and accountability for State psychiatric hospital utilization. The plan shall include all of the following:

(1) LME purchase of bed days from State psychiatric hospitals.

(2) LME monitoring of patient progress while in State psychiatric hospitals.

(3) Direct LME involvement in the development and implementation of discharge plans for patients in State psychiatric hospitals.

(4) A recommendation regarding sufficient LME funding to implement the plan.

The Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than March 1, 2008.

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

VISITOR REGISTRATION SHEET

Senate Health Care — **April 18, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Phil Bazemore	Mayor Pro Tem, City of Monroe
MaryAnn Rasberry	Union County Partnership for Children
S. Taylor	Smart Start
Mary Bost	AARP - NC
Bill Wilson	AARP - NC
Barbara Carson	BCBSNC
Lisa Piercy	NC Dental Society

VISITOR REGISTRATION SHEET

Senate Health Care — **April 18, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lee-Ann Pennington	DCC
John J Bowdish	Astra Zeneca
Susan C. Perritt	NC DTH
Deborah C Lefevers, RDH	NC. Dental Hygiene Educators Assn. & NC Dental Hygiene Assn.
Linda V. Swarts	NC Dental Hygiene Assoc.
Martha Sexton Taylor	NC Dental Hygiene Assoc.
Jackie Ruggiero	Dental Hygienist
Ashley Campbell	Raydale Liggett
Donna Collins	Dental Hygiene Assoc.
Julia Leggett	ADA-CIL
Bill Lott	Raydale Lyott

VISITOR REGISTRATION SHEET

Senate Health Care — **April 18, 2007**
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barney Callen	229 Falcons Way Pittsboro, NC 27312
Kara Schoo	N.C. coalition for Lobbying + Govt. Reform
Nicole Della Rocco	"
Tommy Suter	Wyeth
Gary Salamido	GSK
[illegible]	NCICU
[illegible]	NCSA
Dana Simpson	Smith Anderson
[illegible]	Cardon
Chris Hayes	Civitas
Jami Fitzgerald	NCFPC

VISITOR REGISTRATION SHEET

Senate Health Care — **April 18, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve SLott	P.O. Box 1744 Burlington, NC
GARY OYSTER	4901 Leigh Dr Ral N.C. 27616
Richard Hunt	111 Candlewood Rd Rocky Mount, NC 27804
PRISCILLA M. ALLEN	NC Dental Society PO Box 4099, Cary, NC 27519
Alec Parker	"
Dayle Manley	"
Bobby D. White	NC State Board of Dental Examiners
Lisa Brown Sheaffer	3320 Edgemont Dr Raleigh NC 27612
Suzanne Williams	NCCCS
Joanne Stevens	Stevens & assoc.
Chip Baggett	NCMS
Steve Keene	NCMS

VISITOR REGISTRATION SHEET

Senate Health Care — **April 18, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Deborah Parker	NCCCS
Kim Jernigan	NCCCS
Theodore F. Mayer, DDS	8100 Harps Mill Rd NC Dental Society Raleigh, NC 27615 Wake Tech Dental Hygiene Faculty
Judy F. McConnell	IOG
Swayn Hamlet	Swayn G. Hamlet & Assoc. DAC Fayetteville, N.C.
Wardie J. Vincent Sr.	Sheriff Northampton County
Johnny M. Williams	Sheriff Warren County
Gary Rollins	DAVITA, INC.
Dixie Mowers	Dialysis Patient here w/ Davita
Sarah Price	BCA
Mark Benson	BCA

Senate Health Care Committee
Wednesday, April 25 2007, 11:00 AM
544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

H424	Study Respite Care	Representative Clary Representative Farmer-Butterfield Representative Moore
SB1090	Amend Social Worker Licensure Laws	Senator Purcell
SB1428	Modify Involuntary Commitment Law/LME Control.	Senator Atwater

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, April 25, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 25, 2007, in Room 544 of the Legislative Office Building, with seventeen members present, and Senator William R. Purcell presiding. Senator Purcell welcomed the committee members present, and introduced the pages and sergeants-at-arms, and welcomed a group of visiting physician assistants from Charlotte.

Senator Purcell recognized Representative Debbie Clary to present her bill, HB414, *Study Respite Care*. There was no discussion, and Senator Jacumin moved for a favorable report.

In Senator Atwater's absence, Senator Nesbitt presented SB1428, *Modify Involuntary Commitment Law/LME Control*. This bill came with a proposed committee substitute, which was adopted. Senator Dorsett pointed out that there seemed to be an inconsistency between the bill's title and wording in the bill. An amendment was proposed to substitute "develop a plan for" for "study" and was approved. Senator Bingham moved for an unfavorable report as to the original bill, favorable as to the approved amendment.

Senator Purcell spoke regarding his bill, SB1090, *Amend Social Worker Licensure Laws.* He put forth an amendment to the bill, which was adopted. Senator Forrester asked about the different levels of certification of licensure. Mr. Jack Register, Director of Advocacy and Legislation for the National Association of Social Workers was asked to comment, and he gave a synopsis of the four different levels. Senator Allran asked if anyone had expressed opposition to the bill, and the response was "no". After a brief discussion Senator Malone moved for an unfavorable report as to the original bill, favorable as to the bill with the amendment.

The meeting adjourned at 11:40 A.M.

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

Stan Bingham
Senator Stan Bingham, Co-Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

CORRECTED COPY

Thursday, April 26, 2007

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

FAVORABLE

H.B. **424** Study Respite Care.

Sequential Referral:	None
Recommended Referral:	None

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

S.B. **1090** Amend Social Worker Licensure Laws.

Draft Number:	55433
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1428** Modify Involuntary Commitment Law/LME Control.

Draft Number:	65238
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 3

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

HOUSE BILL 424

Short Title:	Study Respite Care.	(Public)
Sponsors:	Representatives Clary, Moore, Farmer-Butterfield (Primary Sponsors); England, Faison, and Rapp.	
Referred to:	Health.	

March 1, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RESPITE CARE AND TO RECOMMEND WAYS TO IMPROVE THE CURRENT RESPITE CARE DELIVERY SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Facility Services, Division of Medical Assistance, and the Division of Aging and Adult Services, shall study the availability and delivery of respite care which provides temporary relief for family members and others who care for individuals with disabilities, chronic or terminal illnesses, dementia, or the elderly. The study shall examine the following:

(1) The need and availability of respite care in North Carolina.

(2) The delivery and licensing of respite care in other states and possible models for North Carolina.

(3) The application process for a grant under the Lifespan Respite Care Act of 2006, 42 U.S.C.

(4) The need for separate statutory language pertaining to respite care.

(5) The need, proposed structure, and development timeline for a separate licensure category for respite care.

(6) The development of a Medicaid waiver covering a proposed new licensure category for respite care.

SECTION 1.(b) In response to the study authorized in this section, the Department of Health and Human Services shall present findings and recommendations, including any proposed statutory changes and new licensure categories, to the Study Commission on Aging on or before March 1, 2008.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1090

Short Title:	Amend Social Worker Licensure Laws.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 21, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING CERTAIN PROVISIONS TO ALLOW FOR PROVISIONAL LICENSURE OF CLINICAL SOCIAL WORKERS UNDER THE LAWS REGULATING THE PRACTICE OF SOCIAL WORK.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90B-3 is amended by adding a new subdivision to read:

"**§ 90B-3. Definitions.**

The following definitions apply in this Chapter:

...

(7a) Provisional Licensed Clinical Social Worker. – A person issued a provisional license to provide clinical social work services pursuant to G.S. 90B-7(f).

...."

SECTION 2. G.S. 90B-6(i) reads as rewritten:

"(i) The Board may order that any records concerning the practice of social work and relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board shall be produced by the custodian of the records to the Board or for inspection and copying by representatives of or counsel to the Board. A social worker certified or licensed by the Board shall maintain records for a minimum of 10 years from the date the social worker terminates services to the client and the client services record is closed. A social worker certified or licensed by the Board shall cooperate fully and in a timely manner with the Board and its designated representatives in an inquiry or investigation of the records conducted by or on behalf of the Board."

SECTION 3. G.S. 90B-7(f) reads as rewritten:

"(f) The Board may issue a provisional license in clinical social work to a person who has a masters or doctoral degree in a social work program from a college or university having a social work program approved by the Council on Social Work Education and desires to be licensed as a clinical social worker. The provisional license

may not be issued for a period exceeding two years and the person issued the provisional license must practice under the supervision of a licensed clinical social worker or a Board-approved alternate. Notwithstanding G.S. 90B-6(g), a provisional licensee shall pass the qualifying clinical examination prescribed by the Board within two years to be eligible for renewal of the provisional license. The provisional licensee shall complete all requirements for full licensure within three renewal cycles, or a total of six years, unless otherwise directed by the Board."

SECTION 4. G.S. 90B-10(b) reads as rewritten:

"(b) The following may engage in clinical social work practice without meeting the requirements of G.S. 90B-7(d):

~~(1) A person who has engaged in clinical social work practice for one year prior to the effective date of this act and who properly applies for and pays the required fees for a certificate as a certified clinical social worker prior to January 1, 1993. Notwithstanding the foregoing provision of this subdivision, any applicant who applied for certification pursuant to this subdivision between December 1, 1993, and January 15, 1994, and who is otherwise eligible for certification under this subdivision but for the January 1, 1993, deadline shall be certified.~~

(2) A student completing a clinical requirement for graduation while pursuing a course of study in social work in an institution accredited by or in candidacy status with the Council on Social Work Education.

~~(3) An employee engaged in clinical social work practice exclusively for one of the following employers:~~

~~a. Expired.~~

~~b. A hospital or health care facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes or Articles 5 and 6 of Chapter 131E of the General Statutes.~~"

SECTION 5. Chapter 90B of the General Statutes is amended by adding a new section to read:

"**§ 90B-15. License or certificate to be displayed.**

A person licensed or certified under this Chapter shall conspicuously display the license or certificate issued by the Board at the licensee's or certificate holder's primary place of practice."

SECTION 6. 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 4-25-07

S. B. No. 1090 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page 1, line 19
2 ( ) WHICH CHANGES THE TITLE
3 by rewriting the line to read:
4 " the Board. A social worker licensed by the
5 Board shall maintain records for ".
6
7
8
9
10
11
12
13
14
15
16
17
18
19

SIGNED William A Purcell

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1428

Short Title:	Modify Involuntary Commitment Law/LME Control.	(Public)
Sponsors:	Senator Atwater.	
Referred to:	Health Care.	

March 26, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE MODIFICATIONS TO THE LAWS RELATED TO INVOLUNTARY COMMITMENTS IN ORDER TO GIVE LOCAL MANAGEMENT ENTITIES MORE CONTROL OVER STATE PSYCHIATRIC HOSPITAL UTILIZATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-263(a) reads as rewritten:

"(a) Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility for examination by a physician or eligible ~~psychologist; if~~ psychologist. If a physician or eligible psychologist is not available in the area facility, the person designated to provide transportation shall take the respondent to any physician or eligible psychologist locally available. If a physician or eligible psychologist is not immediately available, the respondent may be temporarily detained in an area ~~facility, if one is available; if~~ facility. If an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the ~~mentally ill, but not~~ mentally ill. In no event may a respondent be detained in a jail or other penal facility."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1428
PROPOSED COMMITTEE SUBSTITUTE S1428-PCS65238-RC-14

Short Title: Increase LME Control/State Psych. Hosp. Use. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A PLAN FOR INCREASING LOCAL MANAGEMENT ENTITIES' CONTROL OVER STATE PSYCHIATRIC HOSPITAL UTILIZATION.

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 plan for increasing local management entities' (LME) responsibility and accountability for State psychiatric hospital utilization. The plan shall include all of the following:

(1) LME purchase of bed days from State psychiatric hospitals.

(2) LME monitoring of patient progress while in State psychiatric hospitals.

(3) Direct LME involvement in the development and implementation of discharge plans for patients in State psychiatric hospitals.

(4) A recommendation regarding sufficient LME funding to implement the plan.

The Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than March 1, 2008.

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

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. 1428 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE CSRC-14[v. 2]

Rep.)
Sen.) Dorsett

1 moves to amend the bill on page 1, line 3
2 ( ) WHICH CHANGES THE TITLE
3 by deleting the word "STUDY"
4 and substituting "DEVELOP
5 A PLAN FOR".)
6
7
8
9
10
11
12
13
14
15
16
17
18
19

SIGNED Katie S. Dorsett

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1428
PROPOSED COMMITTEE SUBSTITUTE S1428-CSRC-14 [v.2]

4/17/2007 10:30:19 PM

Short Title: Increase LME Control/State Psych. Hosp. Use. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY INCREASING LOCAL MANAGEMENT ENTITIES CONTROL OVER STATE PSYCHIATRIC HOSPITAL UTILIZATION.

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 plan for increasing local management entities (LMEs) responsibility and accountability for State psychiatric hospital utilization. The plan shall include all of the following:

(1) LME purchase of bed days from State psychiatric hospitals.

(2) LME monitoring of patient progress while in State psychiatric hospitals.

(3) Direct LME involvement in the development and implementation of discharge plans for patients in State psychiatric hospitals.

(4) A recommendation regarding sufficient LME funding to implement the plan.

The Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than March 1, 2008.

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

SENATE BILL 1428:
Increase LME Control/State Psych. Hosp. Use

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	April 24, 2007
Introduced by:	Sen. Atwater	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition S1428-CSRC-14		Committee Counsel

SUMMARY: Senate Bill 1428 would direct the Department of Health and Human Services (DHHS) to develop a plan for increasing local management entities' (LMEs') responsibility and accountability for use of the State's psychiatric hospitals. The plan must include: LME purchase of patient bed days, LME monitoring of patient progress in the hospital, direct LME involvement in the development and implementation of patient discharge plans, and a recommendation regarding sufficient funding to implement the plan. DHHS must submit its plan to the Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services by March 1, 2008.

The Proposed Committee Substitute completely rewrites the original bill.

The bill is effective when it becomes law.

CURRENT LAW: In 1999, the United States Supreme Court held that States have an obligation to provide community-based treatment for persons with mental disabilities when: (1) State medical professionals determine community placement is appropriate; (2) placement would be less restrictive and is not opposed by the patient; and (3) community placement can be reasonably accommodated, given resources available to the State and the needs of others with mental disabilities.[1] In response to that ruling and also findings from a number of studies, the General Assembly directed DHHS to develop a plan to reduce the number of State psychiatric hospitals.

In 2001, the General Assembly passed the Mental Health Reform Act (S.L. 2001-437), which required area mental health programs (LMEs) to develop business plans that included how the LME would manage utilization of State hospital bed days.[2] In 2003, the General Assembly directed DHHS to develop a plan to construction of a replacement facility for Dorothea Dix Hospital and for the transition of patients to the community or to other long-term care facilities, as appropriate.[3] These measures have not resulted in a significant increase in LME control over State psychiatric use.

BACKGROUND: On February 6, 2007, the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services notified the CEOs of North Carolina's community hospitals that due to increased admissions, the State psychiatric hospitals would delay involuntary commitment admissions from community hospitals in those instances when the State facility's admission unit exceeds 110% of the unit's capacity. Some of the statistics related to those increases admissions include:

- Between 2001 and 2005, State psychiatric hospital resident populations decreased by more than 40%, but overall admissions increased by 13% which is higher than the State's population growth for that same time period.
- Admissions pressure has caused patients to be discharged sooner. The number of persons discharged from a State psychiatric hospital after one to seven days has increased 83% between 2001 and 2005.

S1500e1-SMRC-PCS

[1] Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act.
[2] G.S. 122C-115.2(b)(1)c.
[3] S.L. 2003-284, Sec. 10.12(a).

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 25, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Lewis	Covenant w/ NC's Children
Trishana McKendall	YAIO
Jennifer Malan	MHA-NC
[signature]	NCDS & NCPNA
Joanne Stevens	Stevens & Assoc.
April Culver	Johnston Memorial Hospital
ANN LORE	DVLS
Ernie Zapata	DHHS - DFS - ACLS
[signature]	Poyner & Spruill
[signature]	NC Child Coalition
Alex Goldstein	MHA-NC

1

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 25, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
C Baggett	NCMS
Paul Lanier	CFTF
Bud Shelton, PA	NCMS
Nancy Hill	RN
Jeri Hill	Physician Assistant - NCMS
Nikki Dougherty	PA-C NCMS - VA Salisbury
Allison Clapp	NCMS
Shannon Crane	DAAS
Mary Edwards	DAAS
Glenda Artis	DAAS
Bill Wilson	AARP

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 25, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby F. Emanuelson	NMSS
Barbara Canaday	BSCOR
J. Craig Jones	UHS
David Diamont	East Surry H.S.
Ryan Haymore	" "
Anna Mitchell	" "
Stephanie Gasperard	" "
Rebekah Horn	" "
Hannah Widhuson	" "
Pengeka Bonner	East Surry H.S.
Andrea Homayutt	East Surry

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **APRIL 25, 2007**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack Register	NASW-NC
Robyn Burge	NASW-NC
Dennis Patterson	OSC
Tommy Suter	Wyeth

Senate Health Care Committee

Wednesday, May 2, 2007, 11:00 AM
Room 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 353	**Access to Public Health Information.-AB**	**Representative England, M.D. Representative Glazier**
HB 628	**Uniform Sliding Fees - MH/DD/SA Services.**	**Representative Insko**
SB 812	**Safety Restraint Systems on School Buses.**	**Senator Forrester**
SB 1337	**Amend Dental Hygiene Act.**	**Senator Purcell**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, May 2, 2007 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 2, 2007 in Room 544 of the Legislative Office Building, with nineteen 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 introduced was a group of physicians from the NC Psychiatry Association and several more Doctors from all over the state. Senator Kinnaird wanted to point out how many women Doctors there were and how this pleased her.

Senator Bingham stated that two bills have been removed from the calendar, but the committee would hear, SB 812 and SB 1337, beginning with SB 812, ***Safety Restraint Systems on School Buses***, which had a Proposed Committee Substitute. Senator Dannelly made the motion to hear the PCS. The motion carried. Senator Dr. Forrester was called to explain the bill. He pointed out that the difference between the PCS and the original bill was the PCS is a study bill. The original bill was to implement putting seat belts on all school buses when enacted. The new school buses built this year, 800 – 900, would cost $10,000.00 per bus plus they would have to modify some of the buses. Sen. Forrester stated it got complicated when the money was eight to nine million dollars of additional money for the new school buses. Senator Dr. Forrester stated that after further discussions he decided to put it in a study bill and send it to the Child Fatality Task Force. Selena Berrier, the Executive Director was present at the committee meeting. Senator Dr. Forrester stated there were five Senate Members on the Child Fatality Task Force Committee. Senator Kinnaird moved for a favorable report at the appropriate time. Senator Hagan spoke in favor of the bill and was disappointed they were moving it to a study bill. Senator Forrester stated the reason for moving the bill to a study was the opposition of the NC School Board. Senator Hoyle stated he introduced a bill to install seat belts twelve years ago. At the time they indicated the seat belts were very difficult to maintain. The children put chewing gum and pennies in them and then if a buckle got stuck and there was an accident the buckle could flap around it and do more damage than if there were none. Senator Hoyle liked the idea of a study. Senator Dannelly stated that school children are required to be buckled up at home and should be taught at an early age to respect seat belts, so they would not make them dysfunctional, being aware seat belts are for their safety. Senator Malone offered a favorable report motion. Senator Bingham stated that Senator Kinnaird offered a motion earlier. The vote was taken, Unfavorable to Original Bill, but Favorable as to the Committee Substitute Bill, and passed unanimously.

Senator Dr. Purcell was recognized to present SB 1337, ***Amend Dental Hygiene Act***. Senator Dr. Purcell made the motion to adopt the Proposed Committee Substitute for discussion stating it was version eight. Senator Dr. Purcell pointed out this was a compromise bill between the Dentist and the Hygienists both having been able to resolve

their differences. Senator Purcell asked Dr. Richard Hunt, a general dentist from Rocky Mount, and the President of the NC Dental Society this year, to speak to the bill. He stated this bill was very different from the one two weeks ago and expressed thanks for the two weeks they had to work through these issues. Senator Dorsett asked if the Dentist had to evaluate the patient every 120 days even though the Hygienists were still doing procedures. Sen. Purcell answered, that was correct. Sen. Dr. Forrester asked if the bill allowed hygienists to work in the Dentist office without direct supervision of a Dentist. Sen. Purcell answered that the Dentist had to be present if the work was preformed in the office. Sen. Jones asked about the equipment. Martha Taylor, NC Dental Hygienist Association, stated there is portable equipment to be used in an off-site setting. Sen. Dannelly moved for a favorable report. Sen. Rand wanted to thank the parties for their hard work at arriving at the compromise, stating it had been difficult for them for several years. He stated he was delighted to see that they have come together. Sen. Allran asked, prior to voting, if the dentists were concerned about dental hygienists doing cleanings because of the danger that could be involved if proper procedures were not followed. Dr. Hunt stated both sides have agreed and the bill passed, unfavorable as to the Original Bill, but favorable as to the Committee Substitute Bill.

The meeting adjourned at 11:45 A.M.

Senator Stan Bingham, Co-Chair

Senator Dr. William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, May 02, 2007

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

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

S.B. **812** Safety Restraint Systems on School Buses.

Draft Number:	55441
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **1337** Amend Dental Hygiene Act.

Draft Number:	55442
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 353

Committee Substitute Favorable 4/11/07

Short Title: Access to Public Health Information.-AB (Public)

Sponsors:

Referred to:

February 26, 2007

A BILL TO BE ENTITLED

AN ACT TO PROVIDE ACCESS TO INFORMATION FOR PUBLIC HEALTH PURPOSES IN A MANNER THAT IS CONSISTENT WITH THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) MEDICAL PRIVACY RULE.

The General Assembly of North Carolina enacts:

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

"**§ 130A-15. Access to information.**

(a) Health care providers and persons in charge of health care facilities or laboratories shall, upon request and proper identification, permit the State Health Director to examine, review, and obtain a copy of records containing privileged medical information or information protected under the Health Information Portability and Accountability Act (HIPAA) medical privacy rule, 45 C.F.R. Parts 160 and 164, that the State Health Director deems are necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health.

(b) Confidential or protected health information received by the State Health Director pursuant to this section shall be confidential and shall not be released, except when the release is made pursuant to any other provision of law, to another federal, state, or local public health agency for the purpose of preventing or controlling a disease or public health hazard, or to a court or law enforcement official or law enforcement officer for the purpose of enforcing the provisions of this Chapter or for the purpose of investigating a disease or public health hazard.

(c) A person who permits examination, review, or copying of records, or who provides copies of the records pursuant to subsection (a) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed."

SECTION 2. G.S. 130A-5(2) reads as rewritten:

"(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order

to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; ~~to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish such records;~~".

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 628*

Committee Substitute Favorable 3/26/07
Committee Substitute #2 Favorable 4/17/07

Short Title: Uniform Sliding Fees - MH/DD/SA Services. (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO CREATE A UNIFORM SLIDING FEE SCHEDULE FOR MH/DD/SA SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-146 reads as rewritten:

"**§ 122C-146. Fee for service.**

(a) The ~~area authority~~LME and its contractual provider agencies shall ~~prepare fee schedules~~ implement the standardized fee schedule and sliding fee schedule adopted by the Secretary ~~for services and~~ under G.S. 122C-112.1(a)(34). An LME that provides services and its contractual provider agencies shall also make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party ~~payment, except that individuals~~ payments. However, no individual may be refused services because of an inability to pay.

(b) Individuals may not be charged for free services, as required in "The Amendments to the Education of the Handicapped Act", P.L. 99-457, provided to eligible infants and toddlers and their families. This exemption from charges does not exempt insurers or other third-party payors from being charged for payment for these services, if the person who is legally responsible for any eligible infant or toddler is first advised that the person may or may not grant permission for the insurer or other payor to be billed for the free services. ~~However, no individual may be refused services because of an inability to pay.~~

(c) All funds collected from fees from ~~area authority~~LME operated services shall be used for the fiscal operation or capital improvements of the ~~area authority's~~LME's programs. The collection of fees by ~~an area authority~~an LME that provides services may not be used as justification for reduction or replacement of the budgeted commitment of

local tax revenue. All funds collected from fees by contractual provider agencies shall be used to provide services to individuals in targeted populations."

SECTION 2. G.S. 122C-112.1(a) is amended by adding a new subdivision to read:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:

...

(34) Adopt rules to implement a standard fee schedule and sliding fee schedule to be used by LMEs and by contractual provider agencies under G.S. 122C-146."

SECTION 3. The Secretary of the Department of Health and Human Services shall identify all services that are funded by or through the Department's budget and that do not require income-based criteria in order for an individual to be eligible to receive the service. The Secretary shall develop a proposal for implementing income-based criteria for eligibility for those programs and shall submit the proposal to the General Assembly and the Fiscal Research Division by November 1, 2007.

SECTION 4. Section 1 of this act becomes effective July 1, 2008, and applies to services provided on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 812

Short Title:	Safety Restraint Systems on School Buses.	(Public)
Sponsors:	Senators Forrester; Apodaca, Foriest, Goodall, Hagan, and Tillman.	
Referred to:	Health Care.	

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PASSENGER SAFETY RESTRAINT SYSTEMS BE INSTALLED AND USED ON NEW SCHOOL BUSES OPERATED BY PUBLIC OR PRIVATE SCHOOLS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-249A. Safety restraint systems on public school buses and public school activity buses.**

(a) Unless specifically prohibited by the National Highway Transportation Safety Administration, all public school buses and public school activity buses purchased, leased, or contracted for use in North Carolina on or after July 1, 2008, and assigned to public schools, shall be equipped at all designated seating positions with a combination pelvic and upper torso passenger restraint system.

(b) Local boards of education or school boards are encouraged to evaluate the cost and safety enhancement of installing passenger restraint systems on buses currently owned and operated by the boards. Nothing in this section shall be construed to mean a local board of education or school board is required to equip buses purchased before July 1, 2008, with passenger restraint systems.

(c) For purposes of this section, a "passenger restraint system" means any of the following:

(1) A restraint system that is in compliance with Federal Motor Vehicle Safety Standard 209, for a type 2 seat belt assembly, and with Federal Motor Vehicle Safety Standard 210, as those standards were in effect on the date the school bus was manufactured.

(2) A restraint system certified by the school bus manufacturer that is in compliance with Federal Motor Vehicle Safety Standard 222 and incorporates a type 2 lap/shoulder restraint system.

(d) No person, school district, school board, or organization, with respect to a public school bus or public school activity bus, equipped with passenger restraint system pursuant to this section, may be charged for a violation of this section if a passenger on the school bus fails to use or improperly uses the passenger restraint system."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 812
PROPOSED COMMITTEE SUBSTITUTE S812-CSSQ-14 [v.3]

5/2/2007 9:45:29 AM

Short Title: Study Safety Restraints on School Buses. (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE CHILD FATALITY TASK FORCE TO STUDY ISSUES RELATING TO REQUIRING THE INSTALLATION AND USE OF PASSENGER SAFETY RESTRAINT SYSTEMS ON SCHOOL BUSES.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Child Fatality Task Force shall study and analyze the feasibility of the use of safety restraints by passengers on school buses and school activity buses. In conducting the study, the Task Force shall consider:

(1) A determination whether safety restraints are necessary to enhance the safety of passengers on school buses;

(2) An evaluation of the cost of requiring passenger restraint systems on buses to be purchased, leased, or contracted for use on or after July 1, 2009;

(3) An evaluation of the cost of installing passenger restraint systems on buses currently owned and operated by local boards of education; and

(4) The manner by which the local boards of education may enforce the use of safety restraints by passengers on school buses and school activity buses.

The Task Force shall report its findings and recommendations, including recommended legislation to the 2008 Regular Session of the 2007 General Assembly on or before May 1, 2008.

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

SENATE BILL 812:
Study Safety Restraint Systems on School Buses

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 1, 2007
Introduced by:	Sen. Forrester	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S812-CSSQ-14		Legislative Analyst

SUMMARY: ***Senate Bill 812 directs the Child Fatality Task Force to study the use of passenger safety restraints on school buses and report its findings to the General Assembly not later than May 1, 2008.***

The bill provides the study shall include a determination whether safety restraints are necessary to enhance the safety of pupils, an evaluation of the cost associated with installing passenger restraint systems on buses currently owned, an evaluation of the cost of requiring passenger restraints on buses to be purchased, leased, or contracted for use in the future, and the manner by which the local boards of education may enforce the use of safety restraints by passengers on school buses and school activity buses.

EFFECTIVE DATE: This act is effective when it becomes law.

S0812e1-SMSQ-CSSQ-14

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 812
PROPOSED COMMITTEE SUBSTITUTE S812-PCS55441-SQ-14

Short Title: Study Safety Restraints on School Buses. (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE CHILD FATALITY TASK FORCE TO STUDY ISSUES RELATING TO REQUIRING THE INSTALLATION AND USE OF PASSENGER SAFETY RESTRAINT SYSTEMS ON SCHOOL BUSES.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Child Fatality Task Force shall study and analyze the feasibility of the use of safety restraints by passengers on school buses and school activity buses. In conducting the study, the Task Force shall consider:

(1) A determination whether safety restraints are necessary to enhance the safety of passengers on school buses;

(2) An evaluation of the cost of requiring passenger restraint systems on buses to be purchased, leased, or contracted for use on or after July 1, 2009;

(3) An evaluation of the cost of installing passenger restraint systems on buses currently owned and operated by local boards of education; and

(4) The manner by which the local boards of education may enforce the use of safety restraints by passengers on school buses and school activity buses.

The Task Force shall report its findings and recommendations, including recommended legislation to the 2008 Regular Session of the 2007 General Assembly on or before May 1, 2008.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1337

Short Title:	Amend Dental Hygiene Act.	(Public)
Sponsors:	Senators Purcell; Dannelly and Malone.	
Referred to:	Health Care.	

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA DENTAL HYGIENE ACT TO PROVIDE FOR CERTAIN ACTIVITIES TO BE PERFORMED BY LICENSED HYGIENISTS WITH LIMITED SUPERVISION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(c1) "Limited supervision hygienist" as used in this Article shall mean a dental hygienist who meets the following requirements:

(1) Has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist.

(2) Has an annual CPR certification.

(3) Completes six hours each year of continuing education in medical emergencies.

(c2) "Limited supervision procedure" shall mean taking impressions for study models and opposing casts that are not used for construction of dental appliances, but

may be used for the fabrication of bleaching trays and occlusal guards; applying sealants to teeth that do not require mechanical alteration before the appliance of the sealants; cementing temporary restorations using temporary cement; applying acid etch materials and rinses; applying bonding agents; removing periodontal dressings; placing and removing temporary restorations; applying dentin desensitizing solutions; performing periodontal screening; performing periodontal probing; performing subgingival exploration for or removing hard and soft deposits; applying resorbable antibiotic agents prescribed by a dentist; performing radiographs; administering fluoride treatments; polishing teeth; and cleaning teeth, including cleaning with sonic and ultrasonic power instruments.

(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts and such acts are being performed pursuant to the dentist's order, control and approval."

SECTION 2. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) ~~A~~ Except as provided in subsection (a1) of this section, a dental hygienist may practice only under the supervision of one or more licensed dentists. This subsection shall be deemed to be complied with in the case of dental hygienists employed by or under contract with a local health department or State government dental public health program and especially trained by the Dental Health Section of the Department of Health and Human Services as public health hygienists, while performing their duties for the persons officially served by the local health department or State government program under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services.

(a1) A limited supervision hygienist may perform one or more limited supervision procedures without the supervision of a dentist if all of the following conditions are met:

(1) The limited supervision procedures delegated to the limited supervision hygienist are conducted pursuant to a written order from a licensed dentist.

(2) The limited supervision procedures are conducted within one year of the dentist's in-person evaluation of the patient, which evaluation shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, and a diagnosis of the patient's condition.

A dental hygienist shall not establish or operate a separate care facility that exclusively renders dental hygiene services or limited supervision procedures.

(b) A dentist in private practice may not employ more than two dental hygienists at one and the same time who are employed in clinical dental hygiene positions.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1337
PROPOSED COMMITTEE SUBSTITUTE S1337-CSSQ-19 [v.8]

5/2/2007 10:49:35 AM

Short Title: Amend Dental Hygiene Act. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA DENTAL HYGIENE ACT TO PROVIDE FOR CERTAIN ACTIVITIES TO BE PERFORMED BY LICENSED HYGIENISTS OUTSIDE THE DIRECT SUPERVISION OF A DENTIST.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such ~~acts~~acts except those acts

performed under direction and in compliance with G.S. 90-233(a) or G.S. 90-233(a1) and such acts are being performed pursuant to the dentist's order, control and approval."

SECTION 2. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) A dental hygienist may practice only under the supervision of one or more licensed dentists. This subsection shall be deemed to be complied with in the case of dental hygienists employed by or under contract with a local health department or State government dental public health program and especially trained by the Dental Health Section of the Department of Health and Human Services as public health hygienists, while performing their duties for the persons officially served by the local health department or State government program under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services.

(a1) A dental hygienist who has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist, who completes annual CPR certification, who completes six hours each year of Board-approved continuing education in medical emergencies in addition to the requirements of G.S. 90-225.1, and who is designated by the employing dentist as being capable of performing clinical hygiene procedures without the direct supervision of the dentist, may perform one or more dental hygiene functions as described in G.S. 90-221(a) without a licensed dentist being physically present if all of the following conditions are met:

(1) A licensed dentist directs in writing the hygienist to perform the dental hygiene functions.

(2) The licensed dentist has personally conducted an evaluation of the patient which shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, a diagnosis of the patient's condition, and a specific written plan for treatment.

(3) The dental hygiene functions directed to be performed in accordance with this subsection shall be conducted within 120 days of the dentist's evaluation.

(4) The services are performed in nursing homes; rest homes; long term care facilities; rural and community clinics operated by board approved non-profits; rural and community clinics operated by federal, state, county, or local governments; and any other facilities identified by the Office of Rural Health and approved by the Board as serving dental access shortage areas.

(a2) A dental hygienist shall not establish or operate a separate care facility that exclusively renders dental hygiene services.

(a3) A dental hygienist who has been disciplined by the Board may not practice outside the direct supervision of a dentists under G.S. 90-233(a1). A dentist who has been disciplined by the Board may not allow a hygienist to work outside of that dentist's direct supervision under G.S. 90-233(a1).

(a4) Each dentist who chooses to order dental hygiene services under G.S. 90-233(a1) shall report annually to the Board the number of patients who were treated outside the direct supervision of the dentist, the location in which the services were performed by the hygienist, and a description of any adverse circumstances which occurred during or after the treatment, if any. The dentist's report shall not identify hygienists or patients by name or any other identifier.

(a5) Clinical dental hygiene services shall be provided in compliance with both CDC and OSHA standards for infection control and patient treatment.

(b) A dentist in private practice may not employ more than two dental hygienists at one and the same time who are employed in clinical dental hygiene positions.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1337
PROPOSED COMMITTEE SUBSTITUTE S1337-PCS55442-SQ-19

Short Title: Amend Dental Hygiene Act. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA DENTAL HYGIENE ACT TO PROVIDE FOR CERTAIN ACTIVITIES TO BE PERFORMED BY LICENSED HYGIENISTS OUTSIDE THE DIRECT SUPERVISION OF A DENTIST.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such ~~acts~~acts except those acts

performed under direction and in compliance with G.S. 90-233(a) or G.S. 90-233(a1) and such acts are being performed pursuant to the dentist's order, control and approval."

SECTION 2. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) A dental hygienist may practice only under the supervision of one or more licensed dentists. This subsection shall be deemed to be complied with in the case of dental hygienists employed by or under contract with a local health department or State government dental public health program and especially trained by the Dental Health Section of the Department of Health and Human Services as public health hygienists, while performing their duties for the persons officially served by the local health department or State government program under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services.

(a1) A dental hygienist who has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist, who completes annual CPR certification, who completes six hours each year of Board-approved continuing education in medical emergencies in addition to the requirements of G.S. 90-225.1, and who is designated by the employing dentist as being capable of performing clinical hygiene procedures without the direct supervision of the dentist, may perform one or more dental hygiene functions as described in G.S. 90-221(a) without a licensed dentist being physically present if all of the following conditions are met:

(1) A licensed dentist directs in writing the hygienist to perform the dental hygiene functions.

(2) The licensed dentist has personally conducted an evaluation of the patient which shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, a diagnosis of the patient's condition, and a specific written plan for treatment.

(3) The dental hygiene functions directed to be performed in accordance with this subsection shall be conducted within 120 days of the dentist's evaluation.

(4) The services are performed in nursing homes; rest homes; long-term care facilities; rural and community clinics operated by Board-approved nonprofits; rural and community clinics operated by federal, State, county, or local governments; and any other facilities identified by the Office of Rural Health and approved by the Board as serving dental access shortage areas.

(a2) A dental hygienist shall not establish or operate a separate care facility that exclusively renders dental hygiene services.

(a3) A dental hygienist who has been disciplined by the Board may not practice outside the direct supervision of a dentist under G.S. 90-233(a1). A dentist who has been disciplined by the Board may not allow a hygienist to work outside of that dentist's direct supervision under G.S. 90-233(a1).

(a4) Each dentist who chooses to order dental hygiene services under G.S. 90-233(a1) shall report annually to the Board the number of patients who were

treated outside the direct supervision of the dentist, the location in which the services were performed by the hygienist, and a description of any adverse circumstances which occurred during or after the treatment, if any. The dentist's report shall not identify hygienists or patients by name or any other identifier.

(a5) Clinical dental hygiene services shall be provided in compliance with both CDC and OSHA standards for infection control and patient treatment.

(b) A dentist in private practice may not employ more than two dental hygienists at one and the same time who are employed in clinical dental hygiene positions.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

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

VISITOR REGISTRATION SHEET

Senate Health Care — **May 2, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Derek Graham	NCDPI
Ben Matthews	" "
Kathleen Joyce	NCASA
Robin Zenick	Wake Teen
Marston Crawford	Pediatrician, New Bern
Allison Clapp	NCMS
Jugta Kahai	Oak Island Pediatrics
Sue Ontaneda	Durham Public Schools
Christine Wilder MD	Duke University Dept. Psychiatry
JOHN G. WAGNITZ, MD	SANDHILLS CENTER LME
Susan R. Mims MD	Mission Children's Hospital, Asheville

VISITOR REGISTRATION SHEET

Senate Health Care — **May 2, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bourdieh	AstraZeneca
Joe McMillan	NFIB
Cam Cover	BPMHL
Christine Wunsche	10G-Daily Bulletin
Deborah Leiner	NCPS
Alison Kavanaugh MD	NCPS
Steve Shore	NC Pediatric Society
Laura Beth Mann	NCPS
Kathleen Clarke-Pearson MD	NCPS
Shannelle Campbell, MD	NCPS / UNC-CH
Rita Dagner	SBE

VISITOR REGISTRATION SHEET

Senate Health Care — **May 2, 2007**
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
PAULA A. WOLF	PPHS
O.C. Johnson	IAFF Local 907
Rebel O'Brien	PFFPNC
Tom Bennett	NCACDSS
Jeff Essen	WOODS CHARTER SCHOOL CHAPEL HILL, N.C.
Owen "	"
Elizabeth Essen	"
Deborah C. LeFevers	NC Dental Hygiene Educator's Assn North Carolina Dental Hygiene Assn
Martha Sexton Taylor	North Carolina Dental Hygiene Assoc.
Sarah Preston	ACLU-NC
Jeff Mixon	Civitas
Richard Hux	NLDS

VISITOR REGISTRATION SHEET

Senate Health Care — **May 2, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Betsy Hardin	North Carolina Dental Hygiene Assoc.
Jackie Goggins	229 Falconbridge Pittsboro, N.C. 27312
Anna Munoz RDH	NC Dental Hygienists Assoc. 2231 Dungiven Ct. Garner, NC 27529
Judith Mann	North Carolina Community College System office - Raleigh
[illegible]	[illegible]
ERNIE FLEMING	WARREN CO. COMM. WARRENTON, N.C.
Bob Waters	Franklin Cnty. Comm
Penny Mathes-Young.	Franklin County Comm.
Gary Dyster	Franklinton N.C. 27525
Steve Scott	Burlington, NC
Alec Parker	Cary 27513

VISITOR REGISTRATION SHEET

Senate Health Care — **May 2, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Thaum	Kennedy Covington
Bill Hoffman	Camouflage Coalition
Chip Killian	Nelson Mullins
[illegible]	[illegible]
[illegible]	[illegible]
Roz Savitt	NC Child Care Coalition
Barbara Carolan	BSCOR
Joanne Stevens	Missing
Lisa Piercy	NC Dental Society
Lu-Ann Bryman	NCPA

VISITOR REGISTRATION SHEET

Senate Health Care — **May 2, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Priscilla M. Allen	NC Dental Society, Cary, NC
Palmer Edwards, MD	NC Psychiatric Association Raleigh
Faye Marley	NC Dental Society, Cary, NC
Bill Wilson	AARP
W D Coker	PFFG - IAFF Local 947
M MANN	AICBA
Andrew Silverman	Sen. Kay Hagan
GW Putter	NCDS
[illegible]	UHS

Senate Health Care Committee
Wednesday, May 16, 2007, 11:00 AM
Room 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 862	**UNC Smoke-Free.-AB**	**Senator Purcell**
SB 1538	**County Commr. Authority/Boards & Agencies.**	**Senator Preston**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, May 16, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 16, 2007, in Room 544 of the Legislative Office Building, with 14 members present, and Senator William R. Purcell presiding. Senator Purcell welcomed the committee members present, and introduced the pages and sergeants-at-arms. He then recognized Senator Bingham to welcome a group from Guilford County, consisting of current and past Presidents of High Point Medical Society, Executive Director of High Point Medical Society, and a UNC Medical School Student.

Senator Purcell announced SB 1538, *County Commissioner Authority/Boards and Agencies*, was pulled by request of the bill sponsor and will not be heard.

Senator Purcell then asked Senator Bingham to chair as he presented SB 862, *UNC Smoke Free*, now the only bill on the calendar. Sergeants-at-arms passed out the proposed committee substitute, which was then moved for adoption by Senator Forrester and voted in by the committee. Senator Purcell then presented his bill and was open for questions. Senator Brunstetter asked for clarification about property ownership of the grounds, and was told by Ben Popkin of committee staff that the area included within the grounds would be state property, not private property. Senator Allran inquired about a seeming misrepresentation in the bill's title, and Ben explained that facilities wishing to go smoke free must be exempted from current statute that prohibits regulation of smoking. Senator Jones also wanted clarification about the bill's purpose, to which Senator Purcell responded that that the bill would allow the added entities to prohibit smoking if they so choose. Senator Kinnard voiced her opinions on doing away with the current statute and starting over. Senator Dorsett moved for a report unfavorable as to the original bill, but favorable as to the committee substitute.

The meeting adjourned at 11:16 A.M.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

Rebecca E. Wood, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, May 16, 2007

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

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

S.B. **862** UNC Smoke-Free.-AB

Draft Number:	55479
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 862*
PROPOSED COMMITTEE SUBSTITUTE S862-PCS55479-RD-19

Short Title: UNC Smoke-Free.-AB (Public)

Sponsors:

Referred to:

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO ALLOW REGULATION OF SMOKING ON THE CAMPUSES OF THE UNC HEALTH CARE SYSTEM, THE FACILITIES OF THE EAST CAROLINA SCHOOL OF MEDICINE AND PHYSICIANS PRACTICE PLAN, AND THE BUILDINGS AND GROUNDS OF THE CONSTITUENT INSTITUTIONS OF THE UNIVERSITY OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-596 reads as rewritten:

"**§ 143-596. Definitions.**

As used in this Article, unless the context clearly provides otherwise:

(1) "Grounds" means the area located and controlled by the State that is within 100 linear feet of a building owned, leased, or occupied by the State.

~~(1)~~(1a) "Local government" means any local political subdivision of the State or any authority or body created by any ordinance or rules of any such entity.

(2) "Nonsmoking area" means any designated area where smoking is not permitted.

(3) "Public meeting" means any assemblage authorized by State or local government or any subdivision of State or local government.

(4) "Restaurant" means any building, structure, or area having a seating capacity of 50 or more patrons where food is available for eating on the premises in consideration of payment. The following are not included in determining seating capacity:

a. Seats in any bar or lounge area of a restaurant.

b. Seats in any separate room or section of a restaurant which is used exclusively for private functions.

c. Seats in any open outside area.

(5) "Smoke" or "smokes" or "smoking" means the use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(6) "State government" means the political unit for the State of North Carolina; including all agencies of the executive, judicial, and legislative branches of government."

SECTION 2. 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.~~instruction and the grounds of those buildings.

(6) Facilities of The University of North Carolina ~~health services facilities, wellness centers, enclosed physical education facilities, enclosed student recreational centers, laboratories, or residence halls,~~and the grounds of any of those facilities, 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. For purposes of this subdivision, the term "facilities" means buildings owned, leased as lessor, or the area of the building leased as lessee that is occupied by The University of North Carolina.

(7) **(Effective July 1, 2007)** The North Carolina School of Science and Mathematics.

(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, 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 3. 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.

(11) The facilities, grounds, and walkways of the University of North Carolina Health Care System and of the East Carolina University School of Medicine, Health Sciences Complex, and Medical Faculty Practice Plan."

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

SENATE BILL 862:
UNC Smoke-Free.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	May 11, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin
Version:	PCS to First Edition S862-CSRD		Committee Counsel

SUMMARY: ***Senate Bill 862 would amend Article 64 (Smoking in Public Places) of Chapter 143 (State Departments, Institutions and Commissions) to revise current language authorizing certain University of North Carolina facilities to be designated as nonsmoking. The bill would add the "grounds" of UNC facilities and health care educational buildings as areas that may be designated as nonsmoking and would define "grounds" to be "...the area located within 100 linear feet of a building owned, leased or occupied by State government."[1]***

Senate Bill 862 would also exempt several specific health care facilities (and their grounds and walkways) from the provisions of Article 64, which would enable them to be designated as nonsmoking by the persons in charge of the facilities.

The Proposed Committee Substitute made a technical change to the numbering of subsections contained within Section 1 of the bill and inserted language clarifying the scope of the 'facilities' that would fall within the amended G.S. 143-597(a)(6).

[As introduced, this bill was identical to H760, as introduced by Rep. Holliman, which is currently in House Judiciary II.]

CURRENT LAW: General Statute 143-597(a) sets forth a list of specific "...areas that may be designated as nonsmoking in buildings owned, leased, or occupied by State government.", including the following:

- "(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 make a reasonable effort to provide residential smoking rooms in residence halls in proportion to student demand for those rooms."

BILL ANALYSIS: Senate Bill 862 would amend subdivisions (5) and (6) of G.S. 143-597(a) to add "grounds" to both subdivisions and to insert the term "Facilities of The University of North Carolina..." in place of the current language in subdivision (6). The bill would define "grounds" as "...the area located within 100 linear feet of a building owned, leased or occupied by State government."[2]

Senate Bill 862 would also exempt certain health care facilities (and their grounds and walkways) located on or in close proximity to University of North Carolina campuses from the provisions of Article 64, which would allow them to be designated as nonsmoking[3].

EFFECTIVE DATE: This act is effective when it becomes law. *S0862e1-SMRD-CSRD*

---

[1] G. S. 143-596.
[2] G. S. 143-596.
[3] The University of North Carolina Health Care System, and the East Carolina University School of Medicine, Health Sciences Complex, and Medical Faculty Practice Plan.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 862*

Short Title:	UNC Smoke-Free.-AB	(Public)
Sponsors:	Senators Purcell; Dorsett, Foriest, Kinnaird, Malone, and Rand.	
Referred to:	Health Care.	

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO ALLOW REGULATION OF SMOKING ON THE CAMPUSES OF THE UNC HEALTH CARE SYSTEM, THE FACILITIES OF THE EAST CAROLINA SCHOOL OF MEDICINE AND PHYSICIANS PRACTICE PLAN, AND THE BUILDINGS AND GROUNDS OF THE CONSTITUENT INSTITUTIONS OF THE UNIVERSITY OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-596 is amended to add the following definition in alphabetical order.

"**§ 143-596. Definitions.**

As used in this Article, unless the context clearly provides otherwise:

(1) "Local government" means any local political subdivision of the State or any authority or body created by any ordinance or rules of any such entity.

(2) "Nonsmoking area" means any designated area where smoking is not permitted.

(3) "Public meeting" means any assemblage authorized by State or local government or any subdivision of State or local government.

(4) "Restaurant" means any building, structure, or area having a seating capacity of 50 or more patrons where food is available for eating on the premises in consideration of payment. The following are not included in determining seating capacity:

a. Seats in any bar or lounge area of a restaurant.

b. Seats in any separate room or section of a restaurant which is used exclusively for private functions.

c. Seats in any open outside area.

(5) "Smoke" or "smokes" or "smoking" means the use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(6) "State government" means the political unit for the State of North Carolina; including all agencies of the executive, judicial, and legislative branches of government.

(*) 'Grounds' means the area located within 100 linear feet of a building owned, leased, or occupied by the State."

SECTION 2. 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.~~instruction and the grounds of those buildings.

(6) Facilities of The University of North Carolina ~~health services facilities, wellness centers, enclosed physical education facilities, enclosed student recreational centers, laboratories, or residence halls,~~and the grounds of any of those facilities, 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.

(7) **(Effective July 1, 2007)** The North Carolina School of Science and Mathematics.

(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, 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 3. 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.

(11) The facilities, grounds, and walkways of the University of North Carolina Health Care System and of the East Carolina University School of Medicine, Health Sciences Complex, and Medical Faculty Practice Plan."

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

VISITOR REGISTRATION SHEET

Senate Health Care — **Mau 16, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chr Boyd	NCMS
Steve Lee	NCMS
Douglas Jackson	None
John Boerdick	AstraZeneca
Joey Tetrev	none Just visiting.
Fred Bonn	Bonn & Assoc.
Allison Clapp	NCMS
Jessica Chang	NCMS / Duke
Xiaolong Zhou	NCMS / Duke
Susan Emmett	NCMS/Duke
Amanda Kiely	NCMS / Duke

VISITOR REGISTRATION SHEET

Senate Health Care — **Mau 16, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom VITALIS	Action For Children
Kevin Fitzgerald	UNC
[illegible]	Gov's office
Curtis Dickson	Hertford County Public Health Authority
Jim DeCristo	NCSA
Tommy Suter	Wyeth
Bob Willis	UNC-CH
David Rice	Manning Fulton & Skinner

VISITOR REGISTRATION SHEET

Senate Health Care — **Mau 16, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joshua Evans	NCMS/ cNC
David Moore	NCMS / HPMS
Wilma Bailess	HPMS
VIRGIL WILLARD	HPMS

Senate Health Care Committee
Wednesday, June 6, 2007, 11:00 AM
Room 544, Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 676	**Certificate of Need/County Action.**	**Senator Berger**
HB 353	**Access to Public Health Information.-AB**	**Representative England, M.D. Representative Glazier**
HB 485	**Amend Health Education Curriculum.**	**Representative Justice Representative Brubaker Representative Coleman Representative Haire**
HB 1294	**No Smoking/LTC Facilities.**	**Representative Justice Representative Howard**
HB 1492	**Anesthesiologist Assistants Licensure.**	**Representative England, M.D. Representative Harrell, III**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, June 6, at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 6, 2007, in Room 544 of the Legislative Office Building, with sixteen members present. Senator Stan Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members and introduced the pages and sergeants-at arms.

Senator Bingham stated the committee would take the bills out of order today, beginning with HB 1492, ***Anesthesiologist Assistants Licensure***, since it had already been discussed at a previous meeting. Rep. Harrell was recognized to explain the bill. Rep. Harrell stated NC was suffering from a shortage of nurse anesthetists. This bill would provide comparable providers, which were AA's, Anesthesiologist Assistants. AA's have a very good track record, they were treated equally, and there were no differences in insuring an AA, Anesthesiologist Assistants, verses a CRNA, Certified Registered Nurse Anesthetists. This was a compromise bill between the Anesthesiologist, the Medical Board, the Nursing Board, and the CRNAs. Senator Blake wanted to make sure all four groups agreed on the bill. Rep. Harrell expressed that all parties were agreeable. Senator Brunstetter moved for a favorable report. Senator Bingham stated that HB 1492 had a sequential referral to Finance. The vote was taken and SB 1492 passed.

Senator Bingham moved back to the first bill on the agenda, SB 676, ***Certificate of Need/County Action***, Senator Berger of Franklin. Senator Bingham asked for a motion to adopt the PCS for discussion. Senator Foriest made the motion, which passed. Senator Bingham pointed out the original bill was Senator Berger's, but now the PCS belonged to Senator McKissick who was called on to explain the bill. Senator McKissick first explained that Sen. Berger submitted the bill, but when he (Sen. McKissick) arrived at the Senate it was past the cut-off date to introduce bills and the only way he could get a bill was to piggy-back with some other bill that was not being pursued. Therefore, the Proposed Committee Substitute for SB 676 gutted the first bill and changed the title to, ***Establish State Govt. Pay Equity Study Commission***. Senator McKissick explained the bill allowed for a study commission to be appointed which would have five members appointed by the Governor, five members appointed by the Speaker of the House, and five members appointed by the President Pro Temp of the Senate. The Study Committee would look at pay equity issues in state government. It would be looking primarily at the differentials paid in compensation to female employees as compared to their male counterparts. Senator McKissick stated he knew this was not a subject matter that would traditionally come before the Health Care Committee but this was the only way to piggyback and move the bill forward. Senator Dorsett stated she had submitted this same bill for study in 2003 and 2005. Senator Kinnaird also said it had been introduced in 1996 and 1998 but stated maybe it takes a man to get it passed. Senator Foriest asked if it was just going to look at gender only. Senator McKissick stated it was targeted toward

gender inequities. Senator Dorsett wanted to look at race also, saying race disparities are a lot more blatant than between the sexes and that she would like to offer an amendment to include race as well. Senator Bingham asked staff to draw the amendment for Sen. Dorsett. The bill was temporarily displaced.

Senator Bingham moved on to HB 353, ***Access to Public Health Information.-AB***. Sen. Atwater made the motion to adopt the PCS for discussion. Representative Glazier was recognized to explain the bill. Rep. Glazier stated HB 353 was an agency bill and would add a new section to Chapter 130A of the General Statutes to provide the State Health Director with access to protected medical information if it was deemed necessary to prevent, control, or investigate a disease or health hazard that would present a clear danger to the public health. This came out of the Apex, NC situation and the need to get quick access to medical records to determine what the medical response needed to be from the contaminants of the Apex Explosion. The bill was proposed after consulting with the members of the Task Force on Emergency Preparedness. Rep. Glazier also stated that representatives with the Dept. of Agriculture, the Attorney General's Office, and the Dept. of Health and Human Services, met and drafted the original bill along with getting stakeholders' approval through the Medical Society and the Hospital Association. The additional sections, five and six, are amendments to last year's DWI Reform Legislation. Rep. Glazier expressed there was no opposition. Senator Jones asked who picked up the tab on the required test. Kory Goldsmith, Research Attorney, stated she did not know the answer and Rep. Glazier stated the bill did not change that and he did not ask for that information. Sen. Kinnaird stated there were concerns about people rifling through the files. Rep. Glazier explained it could not violate HIPPA. Sen. Brunstetter moved for a favorable report to the Committee Substitute Bill, unfavorable to Original Bill. The motion carried.

Senator Bingham asked for Sen. McKissick to come back and finish SB 676, ***Establish State Govt. Pay Equity Study Comm.*** Senator Dorsett offered an amendment and Shawn Parker, Research Staff, explained the amendment. He stated that page 2; line 11 would be rewritten to read between men and women as well as race. Then also on page 2, lines 13 – 15 would be rewritten to include segregation between women and men as well as race across and within occupation and payment of lower wage occupations. Sen. Allran asked what they were talking about regarding the segregation between men and women. Sen. Dorsett stated there were a lot of disparities where men and women have the same job and the pay is very different. Sen. Jones asked if this was to study state and private sectors. Sen. McKissick stated it was simply for the employees of the state of NC. Sen. Bingham asked for a vote on the amendment, which passed. Sen. Dorsett moved for a favorable report as amended. The motion was to roll the Amendment into a new PCS, favorable as to the new PCS, unfavorable Original Bill, with a re-referral to Appropriations. The motion passed.

Sen. Bingham moved to the next bill, HB 485, ***Amend Health Education Curriculum***. Rep. Haire was recognized to explain the bill. Sen. Foriest made the

motion to adopt the PCS for discussion. Rep. Haire stated the bill was a sequence to a bill that was adopted in 2001. North Carolina was one of the first states that permitted the surrender of a newborn child, less than seven days old, without the parent being criminally charged with the crime of abandonment. There was a handout that explained the 2001 law (included with minutes). Rep. Haire pointed out that HB 485 was necessary because of an article on WRAL-TV entitled, "Officials: More education needed on Safe Surrender Law" (included with minutes). Also there was another handout with two articles on the same page (included with minutes). The first one was about a mom who abandoned a baby and got a plea deal. The second article, May 10, 2007, in Greenville, was about a woman who left her baby at a fire station. In the second column half way down the article it stated early this year two newborns were found abandoned and later died, one in Rocky Mount and the other in Warsaw. This bill is about LIFE. Rep. Haire reiterated that the issue was if you have a child and felt like you could not keep it, you could surrender the child within seven days. Rep. Haire stated the information is not out there and that people did not know the law. Rep. Haire wanted to compliment Shawn Parker, Research Staff, who pointed out to him that mandatory teaching in health curriculum only applies to the fifth through the ninth grade. HB 485 asked the local Boards of Education to disseminate this information in grades nine through twelve. Rep. Haire pointed out the bill had been expanded to include charter schools, private schools, and non-profit schools, in addition to the public schools. Rep. Haire expressed it was not mandatory to provide this information, but if the non-public schools want it, they could get in touch with DPI and get the information. Sen. Jacumin asked about diminishing the responsibility of the young ladies; why not just give it to the pregnant students? Sen. Bingham pointed out that former State Senator Carpenter had worked on this bill for years. Senator Nesbitt made the motion for a favorable report, unfavorable as to Original Bill, but favorable as to the Committee Substitute Bill. The motion passed.

Senator Bingham explained that HB 1294, ***No Smoking/LTC Facilities***, had a couple of things to be worked out and would be heard next week.

The meeting adjourned at 11:44 A.M.

Senator Stan Bingham, Co-Chair

Senator Dr. William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, June 07, 2007

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

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

S.B. **676** Certificate of Need/County Action.

Draft Number:	55513
Sequential Referral:	None
Recommended Referral:	Appropriations/Base Budget
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **353** Access to Public Health Information.-AB

Draft Number:	30495
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

Wednesday, June 06, 2007

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

FAVORABLE

H.B.(CS #1) **1492** Anesthesiologist Assistants Licensure.

Sequential Referral:	~~None~~ Finance
Recommended Referral:	None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **485** Amend Health Education Curriculum.

Draft Number:	70556
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 676

Short Title:	Certificate of Need/County Action.	(Public)
Sponsors:	Senator Berger of Franklin.	
Referred to:	Health Care.	

March 13, 2007

A BILL TO BE ENTITLED

AN ACT TO ALLOW COUNTIES TO BRING AN ACTION IN SUPERIOR COURT FOR REVIEW OF COMPLIANCE WITH A CERTIFICATE OF NEED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-185 reads as rewritten:

"**§ 131E-185. Review process.**

(a) Repealed by Session Laws 1987, c. 511, s. 1.

(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 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 person, except one of the proponents, to 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. An applicant shall have 15 days immediately following any required public hearing to modify the application and submit the modified application to the Department.

(3) The Department may contract or make arrangements with a person or persons located within each service area for the conduct of such public hearings as may be necessary. The Department shall publish, in each 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.

(a2) When an expedited review has been approved by the Department, no public hearing shall be held. The Department may contact the applicant and request additional or clarifying information, amendments to, or substitutions for portions of the application. The Department may negotiate conditions to be imposed on the certificate of need with the applicant.

(b) Repealed by Session Laws 1991 (Reg. Sess., 1992), c. 900, s. 137(a).

(c) The Department may extend the review period for a period not to exceed 60 days and provide notice of such extension to all applicants. For expedited reviews, the Department may extend the review period only if it has requested additional substantive information from the applicant."

SECTION 2. G.S. 131E-189 reads as rewritten:

"**§ 131E-189. Withdrawal of a certificate of need.**

(a) The Department shall specify in each certificate of need the time the holder has to make the service or equipment available or to complete the project and the timetable to be followed. The timetable shall be the one proposed by the holder of the certificate of need unless the Department specifies a different timetable in its decision letter. The holder of the certificate shall submit such periodic reports on his progress in meeting the timetable as may be required by the Department. If no progress report is provided or, after reviewing the progress, the Department determines that the holder of the certificate is not meeting the timetable and the holder cannot demonstrate that it is making good faith efforts to meet the timetable, the Department may withdraw the certificate. If the Department determines that the holder of the certificate is making a good faith effort to meet the timetable, the Department may, at the request of the holder, extend the timetable for a specified period.

(b) The Department may withdraw any certificate of need, if the holder of the certificate fails to develop the service in a manner consistent with the representations made in the application or with any condition or conditions the Department placed on the certificate of need.

(c) The Department may immediately withdraw any certificate of need if the holder of the certificate, before completion of the project or operation of the facility, transfers ownership or control of the facility, the project, or the certificate of need. Any transfer after that time will be subject to the requirement that the service be provided consistent with the representations made in the application and any applicable conditions the Department placed on the certificate of need. Transfers resulting from death or personal illness or other good cause, as determined by the Department, shall not result in withdrawal if the Department receives prior written notice of the transfer and finds good cause. Transfers resulting from death shall not result in withdrawal.

(d) In the event that the Department fails to review the progress of the project or facility which a certificate of need has been issued, or fails to withdraw a certificate of need as authorized under this section, the board of county commissioners of the county in which the facility or project is located or proposed to be located, may bring an action in superior court against the certificate holder for determination of the holder's compliance or good faith effort to comply with the timetable set forth in the certificate. If the court determines that the holder has not complied or has not made a good faith

effort to comply with the timetable or other conditions placed on the certificate, the court shall order the Department to withdraw the certificate. The holder of the certificate may appeal the decision of the court in accordance with G.S. 131E-188."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 676
PROPOSED COMMITTEE SUBSTITUTE S676-CSSQ-39 [v.1]

6/5/2007 2:41:31 PM

Short Title: Establish State Govt. Pay Equity Study Comm. (Public)

Sponsors:

Referred to:

March 13, 2007

A BILL TO BE ENTITLED

AN ACT CREATING THE STATE GOVERNMENT EMPLOYMENT PAY EQUITY STUDY COMMISSION AND APPROPRIATING FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is created the State Government Employment Pay Equity Study Commission ("Commission"). The Commission shall consist of 15 members appointed as follows:

(1) Five members appointed by the Governor to include:
   a. One person who represents an organization whose primary purpose is to represent the interests of women.
   b. One representative of an organization whose objectives include the elimination of pay disparities between men and women and who has undertaken advocacy, educational, or legislative initiatives in pursuit of that objective.
   c. One representative of a higher education or research institution who has experience and expertise in the collection and analysis of data concerning pay disparities and whose research has been used in efforts to promote the elimination of those disparities.
   d. One person who is an active State employee.
   e. One person who is a retired State employee.

(2) Five members appointed by the Speaker of the House of Representatives to include:
   a. Three members of the House of Representatives.
   b. One person who is knowledgeable about State and federal labor laws.
   c. One person from a private business or firm employing 200 or more employees in this State.

(3) Five members appointed by the President Pro Tempore of the Senate to include:
a. Three members of the Senate.
b. One person who represents an organization whose primary purpose is to represent the interests of State government employees or retirees.
c. One person from a private business or firm employing fewer than 200 employees in this State.

SECTION 1.(b) The Commission shall study:

(1) The extent of wage disparities in State government employment between men and women.
(2) Those factors which cause, or which tend to cause, the disparities, including segregation between women and men across and within occupations and payment of lower wages for work in female-dominated occupations.
(3) Whether dissimilar State government job categories requiring similar education, training, skills, and responsibilities are being compensated with equal pay.
(4) The consequences of the disparities on the efficiency of State government, the State's economy, and the families affected.
(5) Actions, including proposed legislation, that are likely to lead to the elimination and prevention of compensation disparities in State government employment.

The Commission may consider any other matter that the Commission finds relevant to its charge. The Commission may conduct public hearings around the State to solicit firsthand testimony regarding pay equity issues.

SECTION 2. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each appoint a cochair for the Commission. The Commission may contract for consultant services as provided by G.S. 120-32.02. 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 the Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission. Members of the Commission shall receive per diem, subsistence, and travel allowances at the rate established in G.S. 120-3.1. The appointing authority shall fill vacancies.

The Commission, while in the discharge of its 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.

The State Personnel Commission, in conjunction with the Director of the Office of State Personnel, shall designate appropriate staff to serve as liaison to the Commission.

The Office of State Personnel shall complete an analysis of the issues identified for study in subsection 1(b) of this act and submit that analysis, including any findings and recommendations, to the Commission by May 1, 2008, for the Commission's consideration.

SECTION 3. The Commission's interim and final reports shall include the results of the Commission's study as well as recommendations, legislative and otherwise, for the elimination and prevention of disparities in State employee compensation between men and women. The Commission shall submit an interim report to the 2008 Regular Session of the 2007 General Assembly upon its convening. The Commission shall make a final report to the 2009 General Assembly upon its convening and shall terminate upon filing its final report.

SECTION 4. There is appropriated from the General Fund to the General Assembly the sum of twenty-five thousand dollars ($25,000) for the 2007-2008 fiscal year and the sum of twenty-five thousand dollars ($25,000) for the 2008-2009 fiscal year to fund the work of the State Government Employment Pay Equity Study Commission created in Section 1 of this act.

SECTION 5. This act becomes effective July 1, 2007.

SENATE BILL 676:
Establish State Govt. Pay Equity Study Comm

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 5, 2007
Introduced by:	Sen. Berger of Franklin	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S676-CSSQ-39		Legislative Analyst

SUMMARY: ***The Proposed Committee Substitute completely rewrites Senate Bill 676 to create the State Government Employment Pay Equity Study Commission.***

BILL ANALYSIS: Senate Bill 676 would create the State Government Employment Pay Equity Study Commission to study as it relates to State government employment:

- The extent of wage disparities between men and women.
- The factors that cause the disparities and consequences of those disparities.
- Compensation between job categories requiring similar education, training, skills, and responsibilities.
- Actions likely to eliminate and prevent compensation disparities.
- Any other matter the Commission finds relevant to its charge.

The Study Commission shall consist of 15 members as follows:

Five members appointed by the Governor including:

- A representative of an organization that represents the interest of women.
- A representative of an organization whose objectives include the elimination of pay disparities.
- A representative of higher education or research institution who has experience in the collection and analysis of data concerning pay disparities.
- An active State employee.
- A retired State employee.

Five members appointed by the Speaker of the House of Representatives including:

- Three members of the House of Representatives.
- A person knowledgeable about State and federal labor laws.
- A representative from a private business employing 200 or more employees in the State.

Five members appointed by the President Pro Tempore of the Senate including:

- Three members of the Senate.
- A representative of an organization the represents the interest of State government employees or retirees.
- A representative from a private business employing fewer than 200 employees in the State.

Professional staff shall be assigned by the Legislative Services Officer to assist the Study Commission and the State Personnel Commission, in conjunction with the Director of the Office of State Personnel will designate appropriate staff to serve as liaisons to the Study Commission.

The Office of State Personnel is directed to complete an analysis of issues identified in subsection 1(b) of this act and submit the analysis to the Study Commission by May 1, 2008.

The Study Commission shall make an interim report to the 2008 Regular Session of the 2007 General Assembly and shall submit a final report to the 2009 General Assembly. The Study Commission shall terminate upon its filing of its final report.

The bill appropriates $25,000 for the expenses of the Study Commission.

EFFECTIVE DATE: This act becomes effective July 1, 2007.

S0676e1-SMSQ-CSSQ-39

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 676 DATE 6-6-07

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

COMMITTEE SUBSTITUTE X

Rep.)
Sen.) Dorsett

moves to amend the bill on page 2, line 11

( ) WHICH CHANGES THE TITLE

by rewriting the line to read:

" between men and women as well as race."

and on page 2, lines 13-15 by rewriting the lines to read:

" including segregation between women and men as well as race across and within occupations and payment of lower wage occupations.".

SIGNED Katie H. Dorsett

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 676
PROPOSED COMMITTEE SUBSTITUTE S676-PCS55513-SQ-39

Short Title: Establish State Govt. Pay Equity Study Comm. (Public)

Sponsors:

Referred to:

March 13, 2007

A BILL TO BE ENTITLED

AN ACT CREATING THE STATE GOVERNMENT EMPLOYMENT PAY EQUITY STUDY COMMISSION AND APPROPRIATING FUNDS FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is created the State Government Employment Pay Equity Study Commission (Commission). The Commission shall consist of 15 members appointed as follows:

(1) Five members appointed by the Governor to include:
   a. One person who represents an organization whose primary purpose is to represent the interests of women.
   b. One representative of an organization whose objectives include the elimination of pay disparities between men and women and who has undertaken advocacy, educational, or legislative initiatives in pursuit of that objective.
   c. One representative of a higher education or research institution who has experience and expertise in the collection and analysis of data concerning pay disparities and whose research has been used in efforts to promote the elimination of those disparities.
   d. One person who is an active State employee.
   e. One person who is a retired State employee.

(2) Five members appointed by the Speaker of the House of Representatives to include:
   a. Three members of the House of Representatives.
   b. One person who is knowledgeable about State and federal labor laws.
   c. One person from a private business or firm employing 200 or more employees in this State.

(3) Five members appointed by the President Pro Tempore of the Senate to include:
a. Three members of the Senate.
b. One person who represents an organization whose primary purpose is to represent the interests of State government employees or retirees.
c. One person from a private business or firm employing fewer than 200 employees in this State.

SECTION 1.(b) The Commission shall study:

(1) The extent of wage disparities in State government employment between men and women as well as race.
(2) Those factors which cause, or which tend to cause, the disparities, including segregation between women and men as well as race across and within occupations and payment of lower wage occupations.
(3) Whether dissimilar State government job categories requiring similar education, training, skills, and responsibilities are being compensated with equal pay.
(4) The consequences of the disparities on the efficiency of State government, the State's economy, and the families affected.
(5) Actions, including proposed legislation, that are likely to lead to the elimination and prevention of compensation disparities in State government employment.

The Commission may consider any other matter that the Commission finds relevant to its charge. The Commission may conduct public hearings around the State to solicit firsthand testimony regarding pay equity issues.

SECTION 2. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each appoint a cochair for the Commission. The Commission may contract for consultant services as provided by G.S. 120-32.02. 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 the Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission. Members of the Commission shall receive per diem, subsistence, and travel allowances at the rate established in G.S. 120-3.1. The appointing authority shall fill vacancies.

The Commission, while in the discharge of its 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.

The State Personnel Commission, in conjunction with the Director of the Office of State Personnel, shall designate appropriate staff to serve as liaison to the Commission.

The Office of State Personnel shall complete an analysis of the issues identified for study in subsection (b) Section 1 of this act and submit that analysis, including any findings and recommendations, to the Commission by May 1, 2008, for the Commission's consideration.

SECTION 3. The Commission's interim and final reports shall include the results of the Commission's study as well as recommendations, legislative and otherwise, for the elimination and prevention of disparities in State employee compensation between men and women. The Commission shall submit an interim report to the 2008 Regular Session of the 2007 General Assembly upon its convening. The Commission shall make a final report to the 2009 General Assembly upon its convening and shall terminate upon filing its final report.

SECTION 4. There is appropriated from the General Fund to the General Assembly the sum of twenty-five thousand dollars ($25,000) for the 2007-2008 fiscal year and the sum of twenty-five thousand dollars ($25,000) for the 2008-2009 fiscal year to fund the work of the State Government Employment Pay Equity Study Commission created in Section 1 of this act.

SECTION 5. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 353

Committee Substitute Favorable 4/11/07

Short Title: Access to Public Health Information.-AB (Public)

Sponsors:

Referred to:

February 26, 2007

A BILL TO BE ENTITLED

AN ACT TO PROVIDE ACCESS TO INFORMATION FOR PUBLIC HEALTH PURPOSES IN A MANNER THAT IS CONSISTENT WITH THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) MEDICAL PRIVACY RULE.

The General Assembly of North Carolina enacts:

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

"**§ 130A-15. Access to information.**

(a) Health care providers and persons in charge of health care facilities or laboratories shall, upon request and proper identification, permit the State Health Director to examine, review, and obtain a copy of records containing privileged medical information or information protected under the Health Information Portability and Accountability Act (HIPAA) medical privacy rule, 45 C.F.R. Parts 160 and 164, that the State Health Director deems are necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health.

(b) Confidential or protected health information received by the State Health Director pursuant to this section shall be confidential and shall not be released, except when the release is made pursuant to any other provision of law, to another federal, state, or local public health agency for the purpose of preventing or controlling a disease or public health hazard, or to a court or law enforcement official or law enforcement officer for the purpose of enforcing the provisions of this Chapter or for the purpose of investigating a disease or public health hazard.

(c) A person who permits examination, review, or copying of records, or who provides copies of the records pursuant to subsection (a) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed."

SECTION 2. G.S. 130A-5(2) reads as rewritten:

"(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order

to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; ~~to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician patient confidentiality arising out of the furnishing of or agreement to furnish such records;~~".

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 353

Committee Substitute Favorable 4/11/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H353-CSRC-48 [v.1]

6/6/2007 10:45:09 AM

Short Title: Pub. Health Info. Access/HIPPA Clarification. (Public)

Sponsors:

Referred to:

February 26, 2007

A BILL TO BE ENTITLED

AN ACT TO PROVIDE ACCESS TO INFORMATION FOR PUBLIC HEALTH PURPOSES IN A MANNER THAT IS CONSISTENT WITH THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) MEDICAL PRIVACY RULE AND TO CLARIFY THAT OTHER DISCLOSURES ARE GOVERNED BY HIPPA.

The General Assembly of North Carolina enacts:

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

"**§ 130A-15. Access to information.**

(a) Health care providers and persons in charge of health care facilities or laboratories shall, upon request and proper identification, permit the State Health Director to examine, review, and obtain a copy of records containing privileged medical information or information protected under the Health Information Portability and Accountability Act (HIPAA) medical privacy rule, 45 C.F.R. Parts 160 and 164, that the State Health Director deems are necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health.

(b) Privileged medical information or protected health' information received by the State Health Director pursuant to this section shall be confidential and is not a public record under G.S. 132-1. The information shall not be released, except when the release is made pursuant to any other provision of law, to another federal, state, or local public health agency for the purpose of preventing or controlling a disease or public health hazard, or to a court or law enforcement official or law enforcement officer for the purpose of enforcing the provisions of this Chapter or for the purpose of investigating a disease or public health hazard.

(c) A person who permits examination, review, or copying of records, or who provides copies of the records pursuant to subsection (a) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed."

SECTION 2. G.S. 130A-5(2) reads as rewritten:

"(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; ~~to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish such records;~~".

SECTION 3. G.S. 90-21.20B reads as rewritten:

"**§ 90-21.20B. Access to and disclosure of medical information for ~~law enforcement~~ certain purposes.**

(a) Notwithstanding G.S. 8-53 or any other provision of law, a healthcare provider may disclose to a law enforcement officer protected health information only to the extent that the information may be disclosed under the federal Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. 164.512(f), and is not specifically prohibited from disclosure by other state or federal law.

(a1) Notwithstanding any other provision of law, if a person is involved in a vehicle crash:

(1) Any health care provider who is providing medical treatment to the person shall, upon request, disclose to any law enforcement officer investigating the crash the following information about the person:

name, current location, and whether the person appears to be impaired by alcohol, drugs, or another substance.

(2) Law enforcement officers shall be provided access to visit and interview the person upon request, except when the health care provider requests temporary privacy for medical reasons.

(3) A health care provider shall disclose a certified copy of all identifiable health information related to that person as specified in a search warrant or an order issued by a judicial official.

(b) A prosecutor or law enforcement officer receiving identifiable health information under this section shall not disclose this information to others except as necessary to the investigation or otherwise allowed by law.

(c) A certified copy of identifiable health information, if relevant, shall be admissible in any hearing or trial without further authentication.

(d) As used in this section, "health care provider" has the same meaning as in G.S. 90-21.11.

(e) Notwithstanding G.S. 8-53 or any other provision of law, a healthcare provider may disclose protected health information for purposes of treatment, payment or healthcare operations to the extent that disclosure is permitted under 45 C.F.R. 164.506 and is not specifically prohibited by other state or federal law. As used in this subsection, "treatment, payment or healthcare operations" are as defined in the Standards for Privacy of Individually Identifiable Health Information."

SECTION 4. G.S. 8-53.1 reads as rewritten:

"**§ 8-53.1. Physician-patient and nurse ~~privilege waived in child abuse; disclosure of information in impaired driving accident cases.~~privilege; limitations.**

(a) Notwithstanding the provisions of G.S. 8-53 and G.S. 8-53.13, the physician-patient or nurse privilege shall not be a ground for excluding evidence regarding the abuse or neglect of a child under the age of 16 years or regarding an illness of or injuries to such child or the cause thereof in any judicial proceeding related to a report pursuant to the North Carolina Juvenile Code, Chapter 7B of the General Statutes of North Carolina.

(b) Nothing in this Article shall preclude a health care provider, as defined in G.S. 90-21.11, from disclosing ~~information to a law enforcement agency investigating a vehicle crash under the provisions of~~ pursuant to G.S. 90-21.20B."

SECTION 5. G.S. 20-139.1(c) reads as rewritten:

"(c) Blood and Urine for Chemical Analysis. – Notwithstanding any other provision of law, when a blood or urine test is specified as the type of chemical analysis by a law enforcement officer, a physician, registered nurse, emergency medical technician, or other qualified person shall withdraw the blood sample and obtain the urine sample, and no further authorization or approval is required. If the person withdrawing the blood or collecting the urine requests written confirmation of the law enforcement officer's request for the withdrawal of blood or collecting the urine, the officer shall furnish it before blood is withdrawn or urine collected. When blood is withdrawn or urine collected pursuant to a law enforcement officer's request, neither the person withdrawing the blood nor any hospital, laboratory, or other institution, person,

firm, or corporation employing that person, or contracting for the service of withdrawing blood, may be held criminally or civilly liable by reason of withdrawing that blood, except that there is no immunity from liability for negligent acts or omissions. A person requested to withdraw blood or collect urine pursuant to this subsection may refuse to do so only if it reasonably appears that the procedure cannot be performed without endangering the safety of the person collecting the sample or the safety of the person to be tested. If the officer requesting the blood or urine requests a written justification for the refusal, the justification must be provided at the time of the refusal."

SECTION 6. G.S. 20-139.1(d2) reads as rewritten;

"(d2) Notwithstanding any other provision of law, when a blood or urine sample is requested under subsection (d1) of this section by a law enforcement officer, a physician, registered nurse, emergency medical technician, or other qualified person shall withdraw the blood and obtain the urine sample, and no further authorization or approval is required. If the person withdrawing the blood or collecting the urine requests written confirmation of the charging officer's request for the withdrawal of blood or obtaining urine, the officer shall furnish it before blood is withdrawn or urine obtained. A person requested to withdraw blood or collect urine pursuant to this subsection may refuse to do so only if it reasonably appears that the procedure cannot be performed without endangering the safety of the person collecting the sample or the safety of the person to be tested. If the officer requesting the blood or urine requests a written justification for the refusal, the justification must be provided at the time of the refusal."

SECTION 7. This act is effective when it becomes law.

HOUSE BILL 353:
Pub. Health Info. Access/HIPAA Clarification

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 6, 2007
Introduced by:	Reps. Glazier, England	**Summary by:**	Kory Goldsmith
Version:	PCS to Second Edition H353-CSRC-48[v.1]		Committee Counsel

SUMMARY: ***House Bill 353 would add a new section to Chapter 130A of the General Statutes to provide the State Health Director with access to protected medical information if it is deemed "...necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health." The bill would make conforming changes to existing law[1].***

The proposed committee substitute adds Sections 3 and 4 to clarify that federal law applies to a health care provider's release of patient information. Sections 5 and 6 allow a health care provider to refuse to draw blood or collect urine at the request of a law enforcement officer if the provider determines the procedure can not be done safely.

House Bill 353 would be effective when it becomes law.

CURRENT LAW:

Public Health - G.S. 130A-5(2) sets forth, as part of one of the duties of the Secretary of Health and Human Services, language authorizing the provision of "...pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health." Records to be released must be identified as necessary by a joint agreement of a Department of Health and Human Services physician and one of the following: the patient's attending physician, the health care facility's chief of staff, or the health care facility's chief administrator.

Release of Medical Information to Law Enforcement – G.S. 90-21.20B requires a health care provider to release to a law enforcement officer certain information related to a person the health care provider is treating due to an automobile crash.

Blood and Urine Samples requested by law enforcement – G.S. 20-239.1(c) and (d1) require a health care provider to withdraw blood or collect a urine sample from a suspect if requested by a law enforcement officer in the course of investigating whether a driver has operated a motor vehicle while impaired.

BILL ANALYSIS:

House Bill 353 would enact a new section of Chapter 130A of the General Statutes. The new section, G.S. 130A-15. Access to Information, would permit the State Health Director to examine, review or obtain copies of records containing privileged medical information or other HIPAA-protected medical information when the State Health Director deems the information to be "...necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health."

Sections 1 and 2 Confidential or protected health information received by the State Health Director pursuant to this new section would remain confidential and would not be released except in the following situations: release is done pursuant to any other provision of law; release is to another federal,

[1] G.S. 130A-5(2).

state, or local public health agency for the purpose of preventing or controlling a disease or health hazard; or release is to a court or law enforcement official for the purpose of enforcing the provisions of Chapter 130A (Public Health) or investigating a disease or health hazard.

Persons providing copies of records or permitting examination, review or copying or records pursuant to the provisions of the new G.S. 130A-15 would be immune from any civil or criminal liability.

Sections 3 and 4 clarify that health care providers may release protected medical information pursuant to HIPAA.

Sections 5 and 6 allow a health care provider to refuse to collect blood or urine if it reasonably appears the collection will endanger either the person collecting the sample or the person from whom the sample is being taken.

EFFECTIVE DATE: This act is effective when it becomes law.

Ben Popkin contributed substantially to this analysis.

H0353e2-SMRC-CSRC-48v1

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 353

Committee Substitute Favorable 4/11/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H353-PCS30495-RC-48

Short Title: Pub. Health Info. Access/HIPAA Clarification. (Public)

Sponsors:

Referred to:

February 26, 2007

A BILL TO BE ENTITLED

AN ACT TO PROVIDE ACCESS TO INFORMATION FOR PUBLIC HEALTH PURPOSES IN A MANNER THAT IS CONSISTENT WITH THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) MEDICAL PRIVACY RULE AND TO CLARIFY THAT OTHER DISCLOSURES ARE GOVERNED BY HIPAA.

The General Assembly of North Carolina enacts:

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

"**§ 130A-15. Access to information.**

(a) Health care providers and persons in charge of health care facilities or laboratories shall, upon request and proper identification, permit the State Health Director to examine, review, and obtain a copy of records containing privileged medical information or information protected under the Health Information Portability and Accountability Act (HIPAA) medical privacy rule, 45 C.F.R. Parts 160 and 164, that the State Health Director deems are necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health.

(b) Privileged medical information or protected health information received by the State Health Director pursuant to this section shall be confidential and is not a public record under G.S. 132-1. The information shall not be released, except when the release is made pursuant to any other provision of law, to another federal, state, or local public health agency for the purpose of preventing or controlling a disease or public health hazard or to a court or law enforcement official or law enforcement officer for the purpose of enforcing the provisions of this Chapter or for the purpose of investigating a disease or public health hazard.

(c) A person who permits examination, review, or copying of records or who provides copies of the records pursuant to subsection (a) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed."

SECTION 2. G.S. 130A-5(2) reads as rewritten:

"(2) To investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases; to provide, under the rules of the Commission, for the prevention, detection, reporting and control of communicable, infectious or any other diseases or health hazards considered harmful to the public health; ~~to obtain, notwithstanding the provisions of G.S. 8-53, a copy or a summary of pertinent portions of privileged patient medical records deemed necessary for investigating a disease or health hazard that may present a clear danger to the public health. Records shall be identified as necessary by joint agreement of a Department physician and the patient's attending physician. However, if the Department is unable to contact the attending physician after reasonable attempts to do so, or if the Department determines that contacting all attending physicians of patients involved in an investigation would be impractical or would unreasonably delay the inquiry and thereby endanger the public health, the records shall be identified as necessary by joint agreement of a Department physician and the health care facility's chief of staff. For a facility with no chief of staff, the facility's chief administrator may consent to the Department's review of the records. Any person, authorized to have or handle such records, providing copies or summaries of privileged patient medical records pursuant to this subdivision shall be immune from civil or criminal liability that might otherwise be incurred or imposed based upon invasion of privacy or breach of physician-patient confidentiality arising out of the furnishing of or agreement to furnish such records;~~".

SECTION 3. G.S. 90-21.20B reads as rewritten:

"**§ 90-21.20B. Access to and disclosure of medical information for ~~law enforcement~~ certain purposes.**

(a) Notwithstanding G.S. 8-53 or any other provision of law, a health care provider may disclose to a law enforcement officer protected health information only to the extent that the information may be disclosed under the federal Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. § 164.512(f) and is not specifically prohibited from disclosure by other state or federal law.

(a1) Notwithstanding any other provision of law, if a person is involved in a vehicle crash:

(1) Any health care provider who is providing medical treatment to the person shall, upon request, disclose to any law enforcement officer investigating the crash the following information about the person:

name, current location, and whether the person appears to be impaired by alcohol, drugs, or another substance.

(2) Law enforcement officers shall be provided access to visit and interview the person upon request, except when the health care provider requests temporary privacy for medical reasons.

(3) A health care provider shall disclose a certified copy of all identifiable health information related to that person as specified in a search warrant or an order issued by a judicial official.

(b) A prosecutor or law enforcement officer receiving identifiable health information under this section shall not disclose this information to others except as necessary to the investigation or otherwise allowed by law.

(c) A certified copy of identifiable health information, if relevant, shall be admissible in any hearing or trial without further authentication.

(d) As used in this section, "health care provider" has the same meaning as in G.S. 90-21.11.

(e) Notwithstanding G.S. 8-53 or any other provision of law, a health care provider may disclose protected health information for purposes of treatment, payment, or health care operations to the extent that disclosure is permitted under 45 C.F.R. § 164.506 and is not specifically prohibited by other state or federal law. As used in this subsection, "treatment, payment, or health care operations" are as defined in the Standards for Privacy of Individually Identifiable Health Information."

SECTION 4. G.S. 8-53.1 reads as rewritten:

"**§ 8-53.1. Physician-patient and nurse ~~privilege waived in child abuse; disclosure of information in impaired driving accident cases.~~privilege; limitations.**

(a) Notwithstanding the provisions of G.S. 8-53 and G.S. 8-53.13, the physician-patient or nurse privilege shall not be a ground for excluding evidence regarding the abuse or neglect of a child under the age of 16 years or regarding an illness of or injuries to such child or the cause thereof in any judicial proceeding related to a report pursuant to the North Carolina Juvenile Code, Chapter 7B of the General Statutes of North Carolina.

(b) Nothing in this Article shall preclude a health care provider, as defined in G.S. 90-21.11, from disclosing ~~information to a law enforcement agency investigating a vehicle crash under the provisions of~~ pursuant to G.S. 90-21.20B."

SECTION 5. G.S. 20-139.1(c) reads as rewritten:

"(c) Blood and Urine for Chemical Analysis. – Notwithstanding any other provision of law, when a blood or urine test is specified as the type of chemical analysis by a law enforcement officer, a physician, registered nurse, emergency medical technician, or other qualified person shall withdraw the blood sample and obtain the urine sample, and no further authorization or approval is required. If the person withdrawing the blood or collecting the urine requests written confirmation of the law enforcement officer's request for the withdrawal of blood or collecting the urine, the officer shall furnish it before blood is withdrawn or urine collected. When blood is withdrawn or urine collected pursuant to a law enforcement officer's request, neither the person withdrawing the blood nor any hospital, laboratory, or other institution, person,

firm, or corporation employing that person, or contracting for the service of withdrawing blood, may be held criminally or civilly liable by reason of withdrawing that blood, except that there is no immunity from liability for negligent acts or omissions. A person requested to withdraw blood or collect urine pursuant to this subsection may refuse to do so only if it reasonably appears that the procedure cannot be performed without endangering the safety of the person collecting the sample or the safety of the person to be tested. If the officer requesting the blood or urine requests a written justification for the refusal, the justification must be provided at the time of the refusal."

SECTION 6. G.S. 20-139.1(d2) reads as rewritten;

"(d2) Notwithstanding any other provision of law, when a blood or urine sample is requested under subsection (d1) of this section by a law enforcement officer, a physician, registered nurse, emergency medical technician, or other qualified person shall withdraw the blood and obtain the urine sample, and no further authorization or approval is required. If the person withdrawing the blood or collecting the urine requests written confirmation of the charging officer's request for the withdrawal of blood or obtaining urine, the officer shall furnish it before blood is withdrawn or urine obtained. A person requested to withdraw blood or collect urine pursuant to this subsection may refuse to do so only if it reasonably appears that the procedure cannot be performed without endangering the safety of the person collecting the sample or the safety of the person to be tested. If the officer requesting the blood or urine requests a written justification for the refusal, the justification must be provided at the time of the refusal."

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 485

Committee Substitute Favorable 5/22/07

Short Title: Amend Health Education Curriculum. (Public)

Sponsors:

Referred to:

March 6, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE LOCAL BOARDS OF EDUCATION TO ENSURE THAT STUDENTS IN GRADES NINE THROUGH TWELVE RECEIVE ANNUAL HEALTH INSTRUCTION INCLUDING INFORMATION ABOUT THE MANNER IN WHICH A PARENT MAY LAWFULLY ABANDON A NEWBORN BABY WITH A RESPONSIBLE PERSON.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"**§ 115C-47. Powers and duties generally.**

In addition to the powers and duties designated in G.S. 115C-36, local boards of education shall have the power or duty:

...

(50) To Ensure That Certain Students Receive Annual Health Instruction Including Information on Lawfully Abandoning a Newborn Baby. – Local boards of education shall adopt policies to ensure that students in grades nine through 12 receive annual health instruction including information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S. 7B-500."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 485

Committee Substitute Favorable 5/22/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H485-CSSQ-40 [v.2]

6/5/2007 4:30:41 PM

Short Title: Info. On Lawful Abandonment. (Public)

Sponsors:

Referred to:

March 6, 2007

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT STUDENTS IN GRADES NINE THROUGH TWELVE RECEIVE INFORMATION ANNUALLY ABOUT THE MANNER IN WHICH A PARENT MAY LAWFULLY ABANDON A NEWBORN BABY WITH A RESPONSIBLE PERSON.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"**§ 115C-47. Powers and duties generally.**

In addition to the powers and duties designated in G.S. 115C-36, local boards of education shall have the power or duty:

...

(50) To Ensure That Certain Students Receive Information Annually on Lawfully Abandoning a Newborn Baby. – Not later than August 1, 2008, local boards of education shall adopt policies to ensure that students in grades nine through 12 receive information annually on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S. 7B-500."

SECTION 2. G.S. 115C-238.29F(a), as amended by Section 2 of S.L. 2007-59, reads as rewritten:

"(a) Health and Safety Standards. – A charter school shall meet the same health and safety requirements required of a local school administrative unit. The Department of Public Instruction shall ensure that charter 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.

The Department of Public Instruction shall also ensure that charter schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human

papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five though 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Department of Public Instruction shall also ensure that charter schools provide students in grades nine through 12 with information annually on the manner in which a parent may lawfully abandon a new born baby with a responsible person, in accordance with G.S.7b-500."

SECTION 3. G.S. 115C-548, as amended by Section 3 of S.L. 2007-59, reads as rewritten:

"**§ 115C-548. Attendance; health and safety regulations.**

Each private church school or school of religious charter shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to these schools so that they can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to these schools so that they can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Division of Nonpublic Education, Department of Administration, shall also ensure that information is available to these schools so that they can provide information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S.7B-500."

SECTION 4. G.S. 115C-556, as amended by Section 4 of S.L. 2007-59, reads as rewritten:

"**§ 115C-556. Attendance; health and safety regulations.**

Each qualified nonpublic school shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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 the benefits and possible side effects of vaccination for their children.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Division of Nonpublic Education, Department of Administration, shall also ensure that information is available to each qualified nonpublic schools so that the school can provide information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S.7B-500."

SECTION 5. G.S.115C-565, as amended by Section 5 of S.L. 2007-59, reads as rewritten:

"**§ 115C-565. Requirements exclusive.**

No school which complies with this Part shall be subject to any other provision of law relating to education except requirements of law respecting immunization. The Division of Nonpublic Education, Department of Administration, shall provide to home schools information about meningococcal meningitis and influenza and their vaccines. This information may be provided electronically or on the Division's Web page. The 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.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S. 7b-500. This information may be provided electronically or on the Division's Web page."

SECTION 6. This act is effective when it becomes law, and applies beginning with the 2008-2009 school year.

HOUSE BILL 485:
Amend Health Education Curriculum

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 5, 2007
Introduced by:	Reps. Haire, Coleman, Justice, Brubaker	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 485 would ensure that each year public school students (including charter schools) in grades nine through twelve receive information on the manner in which a parent may lawfully abandon a newborn baby. The bill further provides that this information may be made available to students in non-public schools governed by Article 39 of Chapter 115C of the General Statutes.

The Proposed Committee Substitute includes students enrolled in charter schools, private religious schools, qualified non-public schools, and home schools and removes the requirement of annual health instruction for public school students in grades nine through twelve.

[As introduced, this bill was identical to S1446, as introduced by Sen. Snow, which is currently in Senate Education/Public Instruction.]

CURRENT LAW:

Local boards of education have general control and supervision of all matters pertaining to public schools in their respective administrative units and shall enforce the school law in their respective units.[1] In addition local boards of education have the powers and duties as provided in G.S.115C-47.

Charter schools are public schools, but are not under the general control and supervision of local boards of education.

The North Carolina Division of Non-Public Education is the authorized State government office that provides oversight to elementary and secondary private and qualified non-public schools in North Carolina.[2]

BILL ANALYSIS:

Section 1 requires local boards of education to adopt policies to ensure students each year in grades nine through twelve receive information on the manner in which a parent may lawfully abandon a newborn baby in accordance to G.S. 7B-500.

Section 2 has language that is similar to Section 1, but it applies to charter schools.

Sections 3-5 direct the Division of Nonpublic Education to ensure this information is **available** to private and home schools. The State cannot mandate that these students receive the information.

EFFECTIVE DATE: This act is effective when it becomes law and applies beginning with the 2008-2009 school year.

[1] G.S. 115C-36
[2] G.S. 115C-533 and G.S. 115C-561

BACKGROUND:

In 2001, the General Assembly enacted legislation (S.L. 2001-291, HB 275) that decriminalized the abandonment of an infant less than seven days old under certain circumstances.

The act allows for the parent of an infant less than 7 days of age who does not express an intent to return for the infant to voluntarily deliver the newborn to one of the following persons and not be subject to prosecution under G.S. 14-318.2 (misdemeanor child abuse, for acts or omissions related to the care of the infant):

1. A health care provider who is on duty or at a hospital, local or district health department, or nonprofit community health center.
2. A law enforcement officer who is on duty or at a police station or sheriff's department.
3. A social services worker who is on duty or at a local department of social services.
4. A certified emergency medical service worker who is on duty or at a fire station or emergency medical services station.
5. Any adult who willingly accepts the infant.

The parent may be prosecuted under G.S. 14-318.4, felony child abuse, but proper delivery can be treated as a mitigating factor in the sentencing of a conviction under that law.

H0485e2-SMSQ

REP. PHIL HAIRE

Mom who abandoned baby gets plea deal

Judge gives probation to woman who left newborn in McDonald's bathroom

BY SARAH OVASKA
STAFF WRITER

RALEIGH – The woman who left her newborn child in the bathroom stall of a Zebulon McDonald's restaurant was sentenced to probation Wednesday.

Michelle Dawn Richardson, 27, pleaded guilty to a misdemeanor count of child abuse in a Wake County courtroom, said Jeff Cutler, her attorney.

She received five years of supervised probation in exchange for her plea.

The baby boy is being cared for under the supervision of Wake County Human Services. Richardson is trying to regain custody, Cutler said.

Richardson now wants to regain custody of the boy.

The newborn was found Dec. 7 wedged between a toilet and wall by a McDonald's restaurant patron.

Richardson delivered the baby at home. She was initially charged with felony counts of abandonment and child abuse. Those charges were dropped partly because the baby was not injured and was under six months of age.

In previous court hearings, her attorneys said that Richardson had been separated from her boyfriend of nine years and initially stopped by the Wendell fire and Emergency Medical Services stations to drop off the baby. She left thinking the emergency crews were out on calls.

But if she had left the baby with them, she wouldn't have faced any criminal charges. North Carolina law allows for infants younger than 7 days old to be left in the care of responsible adults.

Richardson has joint custody of a toddler son with her exboyfriend, also thought to be the father of the infant boy, Cutler said. She also mothered a set of twins whom she gave up for adoption.

Richardson voluntarily had an intrauterine device inserted, which is a form of birth control that will last for five years, Cutler said.

She also has pending embezzlement charges, accusing her of stealing from an employer.

Staff writer Sarah Ovaska can be reached at 829-4622 or sarah.ovaska@newsobserver.com.

THURSDAY, APRIL 26, 2007

THE NEWS & OBSERVER **ng**

Nyo May 10, 2007

Woman leaves newborn at Greenville fire station

BY JERRY ALLEGOOD
STAFF WRITER

GREENVILLE – A woman came to the Greenville Fire/Rescue Department station Monday evening with a tiny parcel and a plaintive question.

"Is this the place you drop off babies?"

Tony Smart, a battalion chief for the department, said the woman left a baby girl with the members of the department. It was the department's first experience with the safe surrender law, which allows a parent to give up a child to an appropriate agency without facing criminal charges.

He said the woman, who was riding in a car, arrived about 7:30 p.m. and said she had given birth about 30 minutes earlier.

"She said, 'I'm not able to take care of it. Here it is,' " he said.

He said the child was taken to Pitt County Memorial Hospital in Greenville.

"As far as I know, the baby was fine," he said.

Smart said he could not discuss the incident in detail.

According to the N.C. Department of Health and Human Services, the state's Safe Surrender Law allows an overwhelmed mother to surrender her newborn to a responsible adult. Under the law, an infant up to 7 days old may be surrendered in an anonymous and legal way.

Hospital officials referred questions about the infant to the Pitt County Department of Social Services. Department spokeswoman Margaret Dixon said she could not discuss the baby's condition or the incident.

"If I did know something, I couldn't tell you," she said.

She said state law allows the department to petition for rights to a child under the safe surrender law, or the parent could terminate parental rights. Then a child could be offered for adoption.

Proponents say the law helps protect infants who might otherwise die for lack of care. Earlier this year, two newborns were found abandoned and later died. One of the babies was found in Rocky Mount and the other in Warsaw.

"We want the public to know there's an option," Dixon said. "We don't want things to come to a tragic end like it has in some places."

Dixon said the incident this week was a first for her department. "I think this mother should be commended," she said.

SAFE SURRENDER

To learn more about the provision for safely and legally surrendering an infant, go to www.safesurrender.net

Staff writer Jerry Allegood can be reached in Greenville at (252) 752-8411 or jerry.allegood@news[illegible]er.com.

REP PHIL HAIRE

HELP PROTECT INNOCENT LIFE BY REQUIRING EDUCATION

What is North Carolina's Safe Haven Law?

- In 2001, the North Carolina General Assembly, with guidance from the Health Law Section of the North Carolina Bar Association, enacted the Safe Haven Infant Abandonment Law, allowing parents to surrender or give up their baby confidentially without being arrested or put on trial for abandonment.

- Under the law, a parent who is not willing or able to care for a newborn can anonymously and voluntarily leave an infant, under seven days old, with certain healthcare providers.

- The parent is not required to provide any information or names and is not subject to criminal prosecution or child support.

The Statistics:

- A study by the University of North Carolina at Chapel Hill estimated that 85 newborns are killed or left to die each year by a parent in the United States.

- The study also reported that 2.1 per 100,000 newborns in NC are killed or left to die each year.

- These numbers are only estimates, as the actual number of infant abandonments is difficult to determine since it is unknown how may abandoned infants are never located.

- The UNC study also showed that the average age of the mother abandoning the infant is 19.1 years old and that more than half of them are 18 years or older.

What is the problem with the current law?

- When the North Carolina General Assembly originally passed the Safe Haven Infant Abandonment Law it did not require or provide for a public information campaign, so the law has not been nearly as effective as it could be.

What is the solution?

- To adopt House Bill 485, Amend Health Education Curriculum.

- In doing so, the General Assembly will ensure that students in grades nine through twelve receive annual instruction on how to lawfully abandon a newborn baby.

- Increasing awareness of the Safe Haven Infant Abandonment Law could prevent tragic cases of infant abandonment from occurring in North Carolina.

29984_XX_NCBar 1/10/05 11:04 AM Page 1 (PANTONE 302 C plate)

What is the Safe Haven Law?

It's a law allowing parents to surrender or give up their baby confidentially, without being arrested or put on trial for abandonment.

How does the law work?

A parent who is not willing or able to care for a newborn can anonymously and voluntarily bring an infant, under seven days old, to any of the following "safe haven centers:" hospital, health department, community health center, police or sheriff department, social services department, fire or emergency services station. The parent can also leave the infant with a healthcare provider, law enforcement officer, social worker or certified E.M.S. worker who is on duty, even when they are away from their building or office. The parent does not have to give any information.

Are safe haven centers the only ones who can accept an infant?

No. The law requires the safe haven centers and workers listed above to take an infant, but other adults can voluntarily take the baby if they wish. The adult taking the infant may ask for information, but must tell the parent that the information is not required.

What must someone taking the infant do?

Anyone accepting an infant under this law must protect the health and well-being of the baby. They must also immediately notify social services or local law enforcement that they have received an infant.

Does this mean the parent is reported to the police?

No. Parents who leave an unharmed infant under 7 days old at a Safe Haven or with a responsible adult, indicating they don't intend to return for the baby, can walk away with no prosecution – EVER.

What if the parent is a minor?

The parent's age doesn't matter. Any parent can give up an unwanted infant under the law, safely and confidentially.

What if the person taking the baby asks for information?

The person taking the surrendered infant can ask for information, but must tell the parents that they are not required to answer. Often times, health information is helpful for caring for the infant. Even if parents give their names, they have the same legal protections as those giving up their children anonymously – they cannot be arrested or tried for abandonment.

Can only a parent surrender an infant?

Yes. The law requires the person voluntarily surrendering the infant to be the infant's parent. This could be the mother or the father. Of course, another adult who voluntarily accepts an infant from the parent (see above) would be the appropriate person to turn the infant over to social services or law enforcement. Also, anyone who accepts an infant from an individual believed, in good faith, to be the parent is generally protected from later civil or criminal liability.

What happens to the infant?

The person taking the infant must protect the health and well-being of the infant. When a hospital or healthcare entity takes the infant, a healthcare provider will likely examine the infant and perform needed medical treatment. The mother or father may be given a medical questionnaire to gather medical history. While parents do not have to provide any information, filling out a medical history could be very useful in caring for the baby. This form can be taken with the parents and mailed back to the healthcare provider. Once the parents have safely turned over the baby, they are free to go. Social services will take custody of the baby. The baby may be placed in a foster home or other temporary location pending adoption.

Can't the parents just give up the infant for adoption?

Yes. Nothing in this law replaces the existing laws on adoption. Many pregnant women choose in advance to give up their babies for adoption. The Safe Haven law provides a process, often as a last resort, for parents who feel they have no other legal options.

What if parents change their minds?

Although the law applies to a parent "who does not express an intent to return for the infant," the law does not prevent a parent from changing his or her mind. However, parents can lose their rights if the child remains abandoned for 60 days or more.

End Note: Source NCGS §7B-500; NCGS §7B-1111; NCGS §14-318.2 and 318.4; NCGS §14-322.3

© 2005 N.C. Bar Association

For an additional pamphlet, send a self-addressed stamped envelope to:

NC Bar Association
Attn: Safe Haven Pamphlet
PO Box 3688 • Cary, NC 27519

For a packet of information on this topic visit our Web site at: www.ncbar.org

Safe Haven Infant Abandonment Law

Published by the Health Law Section of the North Carolina Bar Association

Preguntas y Respuestas sobre la Ley de Refugio Seguro

(Safe Haven) de Carolina del Norte
Abandono del recién nacido

NORTH CAROLINA BAR ASSOCIATION
SEEKING LIBERTY & JUSTICE

Officials: More Education Needed on Safe Surrender Law

Social workers and public officials said Thursday that they struggle daily to get word out about North Carolina's Safe Surrender Law for mothers to abandon newborns without penalty.

Two babies were left for dead this week in eastern North Carolina. A newborn boy was found on the back steps of an abandoned house in Warsaw on Tuesday afternoon, and another infant boy was found in a Dumpster behind a Rocky Mount supermarket on Wednesday afternoon.

Authorities are awaiting autopsy results in each case to determine whether the infants were alive when they were abandoned.

The Safe Surrender Law allows mothers to leave infants up to 7 days old with a responsible adult -- preferably at a hospital, police or fire station -- without fear of punishment. Since the law took effect in 2001, six children have been surrendered and have survived.

State statistics also show that 24 babies have died after being abandoned in recent years.

Social workers said not enough women know about the law -- or if they do, they're not using it.

"People need to know there is a safe solution to leaving your baby or killing your baby," said Regina Wesley, a social worker with the Cumberland County Health Department.

Wesley said she and other social worker counsel every woman who come to the health department for a pregnancy test about the law.

"(But) we're not reaching the population we need to reach," she said.

"We're very concerned that young people don't understand that there is an option, and I think we need to do some educating," said state Rep. Jim Crawford, D-Granville, who co-sponsored the law six years ago.

Only two infants have been surrendered in Cumberland County since the law was enacted.

"The information is available in all government offices -- the fire department, the police department -- and it's in the hospital," said Mary McCoy of the state's Child Protective Services agency.

Police officers on child fatality teams also promote the law to the public, McCoy said.

Wesley said churches and other organizations need to help spread the news to prevent cases like those in Warsaw and Rocky Mount.

"Babies don't deserve that. Babies are supposed to be loved and nurtured, and everyone deserves a fighting chance," Wesley said.

Reporter: Christi Lowe
Photographer: Michael Joyner
Web Editor: Matthew Burns

29984_XX_NCBar 1/10/05 11:04 AM Page 1 (PANTONE 302 C plate)

What is the Safe Haven Law?

It's a law allowing parents to surrender or give up their baby confidentially, without being arrested or put on trial for abandonment.

How does the law work?

A parent who is not willing or able to care for a newborn can anonymously and voluntarily bring an infant, under seven days old, to any of the following "safe haven centers:" hospital, health department, community health center, police or sheriff department, social services department, fire or emergency services station. The parent can also leave the infant with a healthcare provider, law enforcement officer, social worker or certified E.M.S. worker who is on duty, even when they are away from their building or office. The parent does not have to give any information.

Are safe haven centers the only ones who can accept an infant?

No. The law requires the safe haven centers and workers listed above to take an infant, but other adults can voluntarily take the baby if they wish. The adult taking the infant may ask for information, but must tell the parent that the information is not required.

What must someone taking the infant do?

Anyone accepting an infant under this law must protect the health and well-being of the baby. They must also immediately notify social services or local law enforcement that they have received an infant.

Does this mean the parent is reported to the police?

No. Parents who leave an unharmed infant under 7 days old at a Safe Haven or with a responsible adult, indicating they don't intend to return for the baby, can walk away with no prosecution – EVER.

What if the parent is a minor?

The parent's age doesn't matter. Any parent can give up an unwanted infant under the law, safely and confidentially.

What if the person taking the baby asks for information?

The person taking the surrendered infant can ask for information, but must tell the parents that they are not required to answer. Often times, health information is helpful for caring for the infant. Even if parents give their names, they have the same legal protections as those giving up their children anonymously – they cannot be arrested or tried for abandonment.

Can only a parent surrender an infant?

Yes. The law requires the person voluntarily surrendering the infant to be the infant's parent. This could be the mother or the father. Of course, another adult who voluntarily accepts an infant from the parent (see above) would be the appropriate person to turn the infant over to social services or law enforcement. Also, anyone who accepts an infant from an individual believed, in good faith, to be the parent is generally protected from later civil or criminal liability.

What happens to the infant?

The person taking the infant must protect the health and well-being of the infant. When a hospital or healthcare entity takes the infant, a healthcare provider will likely examine the infant and perform needed medical treatment. The mother or father may be given a medical questionnaire to gather medical history. While parents do not have to provide any information, filling out a medical history could be very useful in caring for the baby. This form can be taken with the parents and mailed back to the healthcare provider. Once the parents have safely turned over the baby, they are free to go. Social services will take custody of the baby. The baby may be placed in a foster home or other temporary location pending adoption.

Can't the parents just give up the infant for adoption?

Yes. Nothing in this law replaces the existing laws on adoption. Many pregnant women choose in advance to give up their babies for adoption. The Safe Haven law provides a process, often as a last resort, for parents who feel they have no other legal options.

What if parents change their minds?

Although the law applies to a parent "who does not express an intent to return for the infant," the law does not prevent a parent from changing his or her mind. However, parents can lose their rights if the child remains abandoned for 60 days or more.

End Note: Source NCGS §7B-500; NCGS §7B-1111; NCGS §14-318.2 and 318.4; NCGS §14-322.3

© 2005 N.C. Bar Association

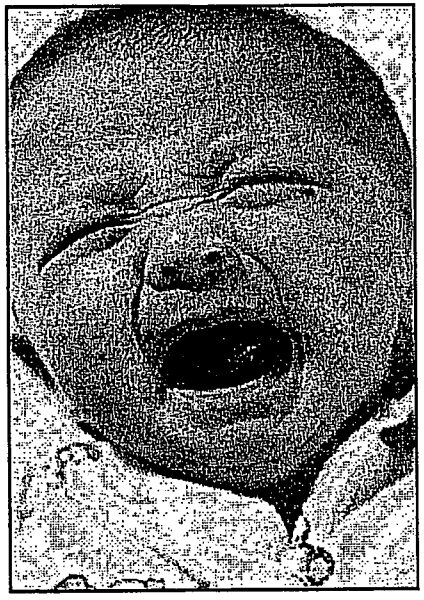
For an additional pamphlet, send a self-addressed stamped envelope to:

NC Bar Association
Attn: Safe Haven Pamphlet
PO Box 3688 • Cary, NC 27519

For a packet of information on this topic visit our Web site at: www.ncbar.org

Safe Haven Infant Abandonment Law

Published by the Health Law Section of the North Carolina Bar Association



Preguntas y Respuestas sobre la Ley de Refugio Seguro

(Safe Haven) de Carolina del Norte
Abandono del recién nacido

NORTH CAROLINA BAR ASSOCIATION
SEEKING LIBERTY & JUSTICE

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 485

Committee Substitute Favorable 5/22/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H485-PCS70556-SQ-40

Short Title: Info. On Lawful Abandonment. (Public)

Sponsors:

Referred to:

March 6, 2007

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT STUDENTS IN GRADES NINE THROUGH TWELVE RECEIVE INFORMATION ANNUALLY ABOUT THE MANNER IN WHICH A PARENT MAY LAWFULLY ABANDON A NEWBORN BABY WITH A RESPONSIBLE PERSON.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:

"**§ 115C-47. Powers and duties generally.**

In addition to the powers and duties designated in G.S. 115C-36, local boards of education shall have the power or duty:

...

(50) To Ensure That Certain Students Receive Information Annually on Lawfully Abandoning a Newborn Baby. – Not later than August 1, 2008, local boards of education shall adopt policies to ensure that students in grades nine through 12 receive information annually on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S. 7B-500."

SECTION 2. G.S. 115C-238.29F(a), as amended by Section 2 of S.L. 2007-59, reads as rewritten:

"(a) Health and Safety Standards. – A charter school shall meet the same health and safety requirements required of a local school administrative unit. The Department of Public Instruction shall ensure that charter 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.

The Department of Public Instruction shall also ensure that charter schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five though 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Department of Public Instruction shall also ensure that charter schools provide students in grades nine through 12 with information annually on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S.7B-500."

SECTION 3. G.S. 115C-548, as amended by Section 3 of S.L. 2007-59, reads as rewritten:

"**§ 115C-548. Attendance; health and safety regulations.**

Each private church school or school of religious charter shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to these schools so that they can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to these schools so that they can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Division of Nonpublic Education, Department of Administration, shall also ensure that information is available to these schools so that they can provide

information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S.7B-500."

SECTION 4. G.S. 115C-556, as amended by Section 4 of S.L. 2007-59, reads as rewritten:

"**§ 115C-556. Attendance; health and safety regulations.**

Each qualified nonpublic school shall make, and maintain annual attendance and disease immunization records for each pupil enrolled and regularly attending classes. Attendance by a child at any school to which this Part relates and which complies with this Part shall satisfy the requirements of compulsory school attendance so long as the school operates on a regular schedule, excluding reasonable holidays and vacations, during at least nine calendar months of the year. Each school shall be subject to reasonable fire, health and safety inspections by State, county and municipal authorities as required by law.

The Division of Nonpublic Education, Department of Administration, shall ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information may be provided electronically or on the Division's Web page. 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 the benefits and possible side effects of vaccination for their children.

The Division of Nonpublic Education, Department of Administration, shall also ensure that materials are provided to each qualified nonpublic school so that the school can provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Division of Nonpublic Education, Department of Administration, shall also ensure that information is available to each qualified nonpublic school so that the school can provide information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S.7B-500."

SECTION 5. G.S. 115C-565, as amended by Section 5 of S.L. 2007-59, reads as rewritten:

"**§ 115C-565. Requirements exclusive.**

No school which complies with this Part shall be subject to any other provision of law relating to education except requirements of law respecting immunization. The Division of Nonpublic Education, Department of Administration, shall provide to home schools information about meningococcal meningitis and influenza and their vaccines. This information may be provided electronically or on the Division's Web page. The 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.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information may be provided electronically or on the Division's Web page. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and the places where parents and guardians may obtain additional information and vaccinations for their children.

The Division of Nonpublic Education, Department of Administration, shall also provide to home schools information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S. 7B-500. This information may be provided electronically or on the Division's Web page."

SECTION 6. This act is effective when it becomes law and applies beginning with the 2008-2009 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 1294

Committee Substitute Favorable 4/26/07
Committee Substitute #2 Favorable 5/10/07

Short Title: No Smoking/LTC Facilities. (Public)

Sponsors:

Referred to:

April 4, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING INSIDE LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.4 reads as rewritten:

"**§ 131D-4.4. Adult care home minimum safety ~~requirements.~~requirements; smoking prohibited inside long-term care facilities; penalty.**

(a) In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

(b) Smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (c) of this section."

SECTION 2. Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.**

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section."

SECTION 3. Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-6. Smoking prohibited; penalty.**

(a) Smoking is prohibited inside facilities licensed under this Chapter and inside State psychiatric hospitals. As used in this section, 'smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, 'inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section."

SECTION 4. Part 3 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-143. Smoking prohibited; penalty.**

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

(1) 'Employee' includes an individual under contract with the home care agency to provide home care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section."

SECTION 5. This act is effective when it becomes law and applies to violations committed on and after that date. G.S. 131D-4.4(c)(3), 131E-114.3(b)(3), and 122C-6(b)(3), as enacted by this act, apply to individuals admitted to the facility on and after the effective date of this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1294

Committee Substitute Favorable 4/26/07

Committee Substitute #2 Favorable 5/10/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1294-CSRD-29 [v.1]

6/5/2007 4:56:54 PM

Short Title: No Smoking/LTC Facilities. (Public)

Sponsors:

Referred to:

April 4, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING INSIDE LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.4 reads as rewritten:

"**§ 131D-4.4. Adult care home minimum safety ~~requirements.~~requirements; smoking prohibited inside long-term care facilities; penalty.**

(a) In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

(b) Smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No

Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (c) of this section. A violation of subsection (c) of this section constitutes a civil offense only and is not a crime."

SECTION 2. Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.**

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section. A violation of subsection (b) of this section constitutes a civil offense only and is not a crime."

SECTION 3. Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-6. Smoking prohibited; penalty.**

(a) Smoking is prohibited inside facilities licensed under this Chapter and inside State psychiatric hospitals. As used in this section, 'smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, 'inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of subsection (b) of this section constitutes a civil offense only and is not a crime."

SECTION 4. Part 3 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-143. Smoking prohibited; penalty.**

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

(1) 'Employee' includes an individual under contract with the home care agency to provide home care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section. A violation of subsection (a) of this section constitutes a civil offense only and is not a crime."

SECTION 5. This act becomes effective October 1, 2007 and applies to violations committed on or after that date. G.S. 131D-4.4(c)(3), 131E-114.3(b)(3), and 122C-6(b)(3), as enacted by this act, apply to individuals admitted to the facility on or after October 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 1492

Committee Substitute Favorable 5/7/07

Short Title: Anesthesiologist Assistants Licensure. (Public)

Sponsors:

Referred to:

April 17, 2007

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF ANESTHESIOLOGIST ASSISTANTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-11 is amended by adding a new subsection to read:

"(a1) Every applicant for licensure as an anesthesiologist assistant in the State shall meet the following criteria:

(1) Satisfy the North Carolina Medical Board that the applicant is of good moral character.

(2) Submit to the Board proof of completion of a graduate level training program accredited by the Commission of Accreditation of Allied Health Education Programs or its successor organization.

(3) Submit to the Board proof of current certification from the National Commission of Certification of Anesthesiologist Assistants (NCCAA) or its successor organization, including passage of a certification examination administered by the NCCAA. The applicant shall take the certification exam within 12 months after completing training.

(4) Meet any additional qualifications for licensure pursuant to rules adopted by the Board."

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~~ licensure 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 licensure 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 in accordance with rules adopted by the Board."

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 to provide anesthesia services 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 without first obtaining a license shall be deemed 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 under the following conditions:

(1) The North Carolina Medical Board has adopted rules governing the provision of anesthesia services by an anesthesiologist assistant consistent with the requirements of subsection (c) of this section.

(2) The anesthesiologist assistant holds a current license issued by the Board or is a student anesthesiologist assistant participating in a training program leading to certification by the National Commission for Certification of Anesthesiologist Assistants and licensure as an anesthesiologist assistant under G.S. 90-11(a1).

(c) The North Carolina Medical Board shall adopt rules to implement this section that include requirements and limitations on the provision of anesthesia services by an anesthesiologist assistant as determined by the Board to be in the best interests of patient health and safety. Rules adopted by the Board pursuant to this section shall include the following requirements:

(1) That an anesthesiologist assistant be supervised by an anesthesiologist licensed under Article 1 of this Chapter who is actively engaged in clinical practice and immediately available on site to provide assistance to the anesthesiologist assistant. One anesthesiologist may supervise no more than two licensed anesthesiologist assistants at one time. However, the limitation shall in no way restrict the number of other qualified anesthesia service providers an anesthesiologist may concurrently supervise.

(2) That no more than two student anesthesiologist assistants be supervised by one anesthesiologist at one time. However, the limitation shall in no way restrict the number of other qualified anesthesia providers an anesthesiologist may concurrently supervise.

(3) That anesthesiologist assistants comply with all continuing education requirements and recertification requirements of the National Commission for Certification of Anesthesiologist Assistants or its successor organization.

After January 1, 2010, the Board may, by rule, allow an anesthesiologist to supervise up to four licensed anesthesiologist assistants concurrently and revise the supervision limitations of student anesthesiologist assistants such that the supervision requirements for student anesthesiologist assistants are similar to the supervision requirements for student nurse anesthetists.

(d) Nothing in this section shall limit or expand the scope of practice of physician assistants under existing law."

SECTION 5. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Senate Health Care — **June 6, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ashley Bell	AHA/ASA
Brian Lewis	Co-chair of NC's Children
Rob Schofield	NC Policy Watch
Karla Kinsko	Amgen
Sherri Coffee	Abbott
Julie Eddy	AstraZeneca
John Bowdish	AstraZeneca
[illegible]	WY
[illegible]	JD, M, PA
Christine Cruz	Wakemed
Erin Schultzely	UNC

VISITOR REGISTRATION SHEET

Senate Health Care — **June 6, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Roscoe	Chapel Hill Int. Med, 940 MLK Jr. BLVD Chapel Hill, NC 27514
Jeanne Chamberlin	"
[illegible]	DLC
Sarah Preston	ACLU-NC
[illegible]	~~NCDHHS~~
Jeff Mixon	Civitas
Rev. Mark Creech	CAL
Selena Berrier	CFTF
Steve Shaw	NCPS
Jim Martin	DPH / TPCB
Leah Devlin	DPH

VISITOR REGISTRATION SHEET

Senate Health Care — **June 6, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris Hoke	DPH
Thomas C. Caves, Jr.	NC Dept. of Crime Control & Public Safety
Pete Jarvis	Gov Office
Bill Baldwin	ABC Law Enforcement
Terry Osborne	ABC Administration
BRIAN ALLGOOD	GRANVILLE COUNTY
Courtney Denning	NC Bar Association
Johanna Chase	NC DPI
[illegible]	SBE
Catherine Blair	NCFPC
Judy McDonnell	ICE

VISITOR REGISTRATION SHEET

Senate Health Care — **June 6, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Glenda Artis	DAAS
Dana Simpson	SA
Chuck Stone	SEARC
Gary Robbins	Alcohol & Co.

Senate Health Care Committee
Wednesday, June 20, 2007, 11:00 AM
544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 1332	**Raise Fee Ceil'g/Amend Hear. Aid Dealer Laws.**	**Senator Purcell**
HB 625	**Amend MH/DD/SA statutes/rename facilities.-AB**	**Representative Insko**
HB 1522	**Local Mgmt Entity/Board Membership.**	**Representative Insko**
HB 1372	**Organ and Tissue Donation/The Heart Prevails.**	**Representative Folwell Representative Clary Representative Holliman Representative Wainwright**
HB 1488	**Amend Psychology Practice Act.**	**Representative Goodwin**
SB 1314	**Amend Massage & Bodywork Therapy Act.**	**Senator Cowell**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, June 20, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:05 A.M. on Wednesday, June 20th, 2007, in room 544 of the Legislative Office Building, with Senator William R. Purcell presiding. Members present were Co-Chair Stan Bingham, Vice Chairs Katie Dorsett, Tony Foriest, James Forrester, and Members Bob Atwater, Doug Berger of Franklin, Harris Blake, Pete Brunstetter, Fletcher Hartsell, Jim Jacumin, and Ellie Kinnaird. Senator Purcell welcomed all present, introduced the pages, and thanked the sergeants-at-arms. He then asked Senator Bingham to chair while he presented his bill, the first on the agenda.

A motion by Senator Forrester to adopt the proposed committee substitute was passed for Senate Bill 1332, *Raise Fee Ceiling/Amend Hearing Aid Dealer Laws.* Senator Purcell presented his bill, and Shawn Parker explained the additional technical changes. Senator Purcell was then open for questions. Senator Dorsett asked about opposition to the bill, and Senator Purcell responded that there was none. She followed up with a question about the high increase in the fee. Mary Chupin, Co-Counsel to the Hearing Aid Dealers and Fitters Board, explained that the Board contracted out with a testing facility to have a more verifiable exam. Senator Forrester asked about the CME requirements from the audiology board, and John Sexton, the chairman of the Hearing Aid Dealers and Fitters Board and previous chair of the Audiology Board, informed him that there are some proposals in legislation currently. Senator Brunstetter asked about the removed sections, and Mary Chupin responded that the language was quite antiquated, making it difficult for the Board to define the behaviors mentioned. Senator Foriest asked if those in need of the services would be affected by the increase in the fee. Senator Purcell responded that the fee would be an increase on the people performing the tests, some of which may or may not be passed down. Senator Forrester made a motion for a favorable report of the committee substitute, unfavorable as to original bill, and the bill was referred to Finance.

Senator Bingham turned the meeting back to Senator Purcell, where he called on bill sponsor Representative Insko to present her bill, HB 625, *Amend Mental Health/Developmental Disabilities/Substance Abuse Statutes/Rename Facilities- AB.* The proposed committee substitute was adopted by Senator Bingham for the purposes of discussion. After explanation of the bill, Senator Dorsett moved for a favorable report of the committee substitute, unfavorable as to original bill. The bill was reported out of the committee and ready for the floor.

Senator Purcell then welcomed members of the audience from Medical Society Leadership College and from High Point to the General Assembly for the day. He then announced that SB 1522, *Local Management Entity/Board Membership,* would be pulled from the day's calendar at the request of the bill sponsor.

The next bill on the calendar, HB 1372, *Organ and Tissue Donation/The Heart Prevails*, presented by Representative Folwell was taken up. Senator Brunstetter moved for adoption of the proposed committee substitute for the purposes of discussion. Representative Folwell explained the bill and was open for questions. Senator Forrester asked for clarification on the law as it affects minors, and Representative Folwell confirmed his interpretation. Senator Brunstetter asked for a more exhaustive explanation of the current state of the law and Representative Folwell consented. Kory Goldsmith from the Research Division was then asked by Senator Purcell to follow-up on Senator Forrester's question, explaining that under this law all that would be required for a minor's wishes to be upheld would be the heart on the license, but that a parent could revoke that. Senator Berger then inquired about removing tissue from the

legislation, saying it was mentioned in the title and not in the bill. Kory Goldsmith explained that the limitation in the bill only covered donation as expressed on drivers' licenses, and did not limit donations made through other mechanisms. She then directed Senator Berger to the places in legislation where manner of donation was discussed. She also discussed the conflict with current health care power of attorney law, and Representative Folwell informed the committee it would be continuing on to Judiciary II to iron out the differences. Senator Hartsell then asked about any other areas that this bill appears to conflict with the advance directives bill that has already passed the Senate, and Ms. Goldsmith answered no. At the inquiry of Senator Berger, Representative Folwell explained the reasons for removing the tissue language. Burton J. Matice, Vice-President of Carolina Donor Services answered Senator Berger's question about potential donors being informed about the consequences of the tissue donation. Senator Berger voiced his opinion about his feelings for the need for the "duty to inform" language. Senator Purcell then recognized Doug Wickham, from LifeTree, speaking against the bill. His comments have been included in the minutes at the request of the speaker (see Attachment 1). Representative Folwell responded to the comments. Senator Purcell then announced we had a motion from Senator Brunstetter for a favorable report of the committee substitute, unfavorable as to original bill. The motion carried and was sent to Judiciary II.

The next bill on the calendar, HB 1488, *Amend Psychology Practice Act,* sponsored by Representative Goodwin, was then taken up for discussion. Senator Bingham offered a technical amendment to the bill and Ben Popkin of the Research staff was recognized to explain the amendment. The amendment passed favorably. Representative Goodwin then presented her bill and stood ready for questions. Senator Kinnaird asked about the supervision requirements for psychologists, and Representative Goodwin deferred to members of the NC Psychological Association to answer. Sally Cameron from the Association said that this particular piece of legislation did not address those concerns, but the General Assembly and the Association have addressed the issue in other areas. Senator Dorsett moved for a favorable report of the bill as amended, and will be rolled into a new proposed committee substitute and be sent to Finance.

SB 1314, *Amend Massage and Bodywork Therapy Act,* was held at the request of the bill sponsor, Senator Janet Cowell.

The meeting adjourned at 11:50 A.M.

William R. Purcell

Senator William R. Purcell, Co-Chair

Stan Bingham

Senator Stan Bingham, Co-Chair

Rebecca E. Wood

Rebecca E. Wood, Committee Assistant

[Attachment]

[ATTACHMENT 1]

Statement concerning House Bill 1372: Organ and Tissue Donation

The medical dilemma which I face as a prospective donor is clear. For vital organs to be successfully taken and transplanted into another person, the donor has only to be declared dead under a variety of available medical criteria. When a person is truly dead, as can be seen after the fact, the vital organs are no longer useful.

When I am encouraged at the DMV to put a symbol on my driver's license, I am hardly given sufficient information to make a medically informed consent. This legislation, however, would (section 10—preclusive effect) lock in my "decision to be a donor" and not permit others (such as my health care agent or spouse) to change it. There is a general pattern in this section on "preclusive effect." Decisions by a donor or other person to make gifts are locked in. Decisions to revoke are not locked in and can be changed even when the donor becomes a "decedent." (Sections 11 and 12).

If I am concerned about this, and do not desire to permit the harvest of my organs under the presently given medical criteria, I might think that doing nothing would suffice. No symbol on my license. This legislation, however, in sections 11 and 12 permits a long list of others to make a decision to donate my organs when I have been declared dead, but may not be truly dead.

It is true that this legislation does permit me to execute a document in which I specifically opt out of organ donation. It is called a refusal in the bill. The bill provides for a registry of those who make, amend or revoke anatomical gifts. However, the rewrite of 20-43.2 provides for keeping track only of those who "make, amend or revoke." My refusal thus will not make its way into the registry. If this happens, sections 11 and 12 allow others to authorize the harvest of my organs unless they have specific knowledge of my declaration to opt out which this legislation calls a refusal.

LifeTree is concerned that life be protected at every stage. It is wrong to impose death on an innocent human being and to participate in its imposition. Likewise, we should not encourage others to participate in organ transplantation unless all doubts about death have been removed. At a minimum, my decision to opt out should be recorded in the registry which reflects so many decisions about organ donation which can hardly be called truly informed.

Elizabeth D. Wickham, PhD
Executive Director, LifeTree
www.lifetree.org
PO Box 17301
Raleigh, NC, 27619
919-785-0855

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, June 20, 2007

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

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

S.B. **1332** Raise Fee Ceil'g/Amend Hear. Aid Dealer Laws.

Draft Number:	75425
Sequential Referral:	Finance
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) **625** Amend MH/DD/SA statutes/rename facilities.-AB

Draft Number:	60372
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1372** Organ and Tissue Donation/The Heart Prevails.

Draft Number:	30499
Sequential Referral:	Judiciary II (Criminal)
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1488** Amend Psychology Practice Act.

Draft Number:	80455
Sequential Referral:	Finance
Recommended Referral:	None

Long Title Amended: No

TOTAL REPORTED: 4

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1332
PROPOSED COMMITTEE SUBSTITUTE S1332-PCS75425-SQf-44

Short Title: Raise Fee Ceil'g/Amend Hear. Aid Dealer Laws. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA STATE HEARING AID DEALERS AND FITTERS BOARD TO RAISE THE CEILING ON CERTAIN FEES AND AMENDING AND UPDATING CERTAIN OTHER PROVISIONS UNDER THE LAWS REGULATING HEARING AID DEALERS AND FITTERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 93D-3(c)(14)f. reads as rewritten:

"(c) The Board shall:

...

(14) Have the power to set and collect fees in accordance with Chapter 150B of the General Statutes for the items listed in this subdivision and for other items for which this Chapter gives the Board the authority to set a fee:

...

f. For administering an examination, a fee not to exceed ~~seventy-five dollars ($75.00);~~three hundred dollars ($300.00); and

...."

SECTION 2. G.S. 93D-3(d) reads as rewritten:

"(d) ~~Out of the funds coming into the possession of said Board, each member thereof may receive as reimbursement for each day he is actually engaged in the assigned duties of his office, the sum of eight cents (8¢) per mile for travel plus the actual costs of meals and public lodging while away from home, which costs of meals and lodging may not exceed twenty dollars ($20.00) per day. Such~~Members of the Board shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5. The expenses shall be paid from the fees and assessments received by the Board under the provisions of this Chapter. No part of these expenses or any other expenses of the Board, in any manner whatsoever, shall be paid out of the State

treasury. All moneys received in excess of expense allowance and mileage, as above provided, shall be held by the secretary-treasurer as a special fund for meeting other expenses of the Board and carrying out the provisions of this Chapter.

~~The secretary-treasurer shall give a bond to the Board to be approved by the Board, in the sum of five thousand dollars ($5,000) conditioned upon the faithful performance of the duties of his office.~~

The Board shall make an annual report of its proceedings ~~to the Governor on the first Monday in June of each year, which report shall contain an account of all moneys received and disbursed by the Board and a complete listing of names and addresses of all licensees and apprentices. Copies of the report and list of licensees and apprentices shall be filed in the office of the State Auditor, the Secretary of State, and Attorney General.~~in accordance with G.S. 93B-2."

SECTION 3. G.S. 93D-5 reads as rewritten:

"(a) No person shall begin the fitting and selling of hearing aids in this State unless the person has been issued a license by the Board or is an apprentice working under the supervision of a licensee. Except as hereinafter provided, each applicant for a license shall pay a fee set by the Board, not to exceed ~~one hundred fifty dollars ($150.00);~~two hundred fifty dollars ($250.00), which fee may be prorated by the Board, and shall show to the satisfaction of the Board that the applicant:

(1) Is a person of good moral ~~character,~~character.

(2) Is 18 years of age or ~~older,~~older.

(3) Has an education equivalent to a four-year course in an accredited high ~~school,~~school.

~~(4) Is free of contagious or infectious disease.~~

(b) Except as hereinafter provided, no license shall be issued to a person until he has successfully passed a qualifying examination administered by the Board.

(c) No license shall be issued to any person until ~~he~~ the person has served as an apprentice as set forth in G.S. 93D-9 for a period of at least one year; provided, that this subsection shall not apply to those persons qualified under G.S. 93D-6 nor to those persons holding masters degrees in Audiology or persons holding doctoral degrees in Audiology from an accredited training program who have undergone 250 hours of supervised activity fitting and selling hearing aids under the direct supervision of a licensed hearing aid dealer approved by the Board, or have met the licensure requirements under Article 22 of Chapter 90 of the General Statutes and have worked full time for one year fitting and selling hearing aids in the office of and under the direct supervision of an otolaryngologist and have participated in 250 hours of Board-supervised, continuing professional education in fitting hearing aids."

SECTION 4. G.S. 93D-11 reads as rewritten:

"**§ 93D-11. Annual fees; failure to pay; expiration of license; occupational instruction courses.**

Every licensed person who engages in the fitting and selling of hearing aids shall pay to the Board an annual license renewal fee in an amount set by the Board, not to exceed ~~one hundred fifty dollars ($150.00). Such~~two hundred fifty dollars ($250.00). The payment shall be made prior to the first day of April in each year. In case of default

in payment the license shall expire 30 days after notice by the secretary-treasurer to the last known address of the licensee by registered ~~mail.~~mail, certified mail, or in a manner provided by G.S. 1A-1, Rule 4(j)(1)d. The Board may reinstate an expired license upon the showing of good cause for late payment of fees, upon payment of said fees within 60 days after expiration of the license, and upon the further payment of a late penalty of twenty-five dollars ($25.00). After 60 days after the expiration date, the Board may reinstate the license for good cause shown upon application for reinstatement and payment of a late penalty of fifty dollars ($50.00) and the renewal fee. The Board may require all licensees to successfully attend and complete a course or courses of occupational instruction funded, conducted or approved or sponsored by the Board on an annual basis as a condition to any license renewal and evidence of satisfactory attendance and completion of any such course or courses shall be provided the Board by the licensee."

SECTION 5. G.S. 93D-13 reads as rewritten:

"**§ 93D-13. Discipline, suspension, revocation of ~~licenses.~~licenses; records.**

(a) The Board may in its discretion administer the punishment of private reprimand, suspension of license for a fixed period or revocation of license as the case may warrant in their judgment for any violation of the rules and regulations of the Board or for any of the following causes:

~~(1) Habitual drunkenness~~

(2) Gross ~~incompetence~~incompetence.

(3) ~~Knowingly fitting and selling hearing aids while suffering with a contagious or infectious disease~~Inability to perform the functions for which the person is licensed or substantial impairment of the person's ability to perform the functions for which the person is licensed by reason of physical or mental disability.

(4) Commission of a criminal offense indicating professional ~~unfitness~~unfitness.

(5) The use of a false name or alias in ~~his business~~his or her business.

(6) Conduct involving willful ~~deceit~~deceit.

(7) Conduct involving fraud or any other business conduct involving moral ~~turpitude~~turpitude.

(8) Advertising of a character or nature tending to deceive or mislead the ~~public~~public.

(9) Advertising declared to be unethical by the Board or prohibited by the code of ethics established by the ~~Board~~Board.

(10) Permitting another person to use ~~his license,~~his or her license.

(10a) Failure by a licensee to properly supervise an apprentice under ~~his supervision, and~~his or her supervision.

(11) For violating any of the provisions of this Chapter.

(b) Board action in revoking or suspending a license shall be in accordance with Chapter 150B of the General Statutes. Any person whose license has been suspended for any of the grounds or reasons herein set forth, may, after the expiration of 90 days but within two years, apply to the Board to have the same reissued; upon a showing

satisfactory to the Board that ~~such~~ reissuance will not endanger the public health and welfare, the Board may reissue a license to such person for a fee set by the Board, not to exceed two hundred dollars ($200.00). If application is made subsequent to two years from date of suspension, reissuance shall be in accordance with the provisions of G.S. 93D-8.

(c) Records, papers, and other documents containing information collected or compiled by or on behalf of the Board as a result of an investigation, inquiry, or interview conducted in connection with registration, licensure, or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes. Any notice or statement of charges, notice of hearing, or decision rendered by the Board in connection with a hearing is a public record. However, information that identifies a consumer who has not consented to the public disclosure of services rendered to the consumer by a person registered or licensed under this Chapter shall be deleted from the public record. All other records, papers, and documents containing information collected or compiled by or on behalf of the Board shall be public records, provided that any information that identifies a consumer who has not consented to the public disclosure of services rendered to the consumer is deleted."

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1332

Short Title:	Raise Fee Ceil'g/Amend Hear. Aid Dealer Laws.	(Public)
Sponsors:	Senators Purcell; Dannelly and Malone.	
Referred to:	Health Care.	

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA STATE HEARING AID DEALERS AND FITTERS BOARD TO RAISE THE CEILING ON CERTAIN FEES AND AMENDING AND UPDATING CERTAIN OTHER PROVISIONS UNDER THE LAWS REGULATING HEARING AID DEALERS AND FITTERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 93D-3(c)(14)f. reads as rewritten:

"(c) The Board shall:

...

(14) Have the power to set and collect fees in accordance with Chapter 150B of the General Statutes for the items listed in this subdivision and for other items for which this Chapter gives the Board the authority to set a fee:

...

f. For administering an examination, a fee not to exceed ~~seventy-five dollars ($75.00);~~three hundred dollars ($300.00); and

...."

SECTION 2. G.S. 93D-3(d) reads as rewritten:

"(d) ~~Out of the funds coming into the possession of said Board, each member thereof may receive as reimbursement for each day he is actually engaged in the assigned duties of his office, the sum of eight cents (8¢) per mile for travel plus the actual costs of meals and public lodging while away from home, which costs of meals and lodging may not exceed twenty dollars ($20.00) per day. Such~~Members of the Board shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5. The expenses shall be paid from the fees and assessments received by the Board under the provisions of this Chapter. No part of these expenses or any other expenses of the Board, in any manner whatsoever, shall be paid out of the State treasury. All moneys received in excess of expense allowance and mileage, as above provided, shall be held

by the secretary-treasurer as a special fund for meeting other expenses of the Board and carrying out the provisions of this Chapter.

~~The secretary-treasurer shall give a bond to the Board to be approved by the Board, in the sum of five thousand dollars ($5,000) conditioned upon the faithful performance of the duties of his office.~~

The Board shall make an annual report of its proceedings ~~to the Governor on the first Monday in June of each year, which report shall contain an account of all moneys received and disbursed by the Board and a complete listing of names and addresses of all licensees and apprentices. Copies of the report and list of licensees and apprentices shall be filed in the office of the State Auditor, the Secretary of State, and Attorney General.~~in accordance with G.S. 93B-2."

SECTION 3. G.S. 93D-5 reads as rewritten:

"(a) No person shall begin the fitting and selling of hearing aids in this State unless the person has been issued a license by the Board or is an apprentice working under the supervision of a licensee. Except as hereinafter provided, each applicant for a license shall pay a fee set by the Board, not to exceed ~~one hundred fifty dollars ($150.00),~~two hundred fifty dollars ($250.00), which fee may be prorated by the Board, and shall show to the satisfaction of the Board that the applicant:

(1) Is a person of good moral ~~character,~~character.

(2) Is 18 years of age or ~~older,~~older.

(3) Has an education equivalent to a four-year course in an accredited high ~~school,~~school.

~~(4) Is free of contagious or infectious disease.~~

(b) Except as hereinafter provided, no license shall be issued to a person until he has successfully passed a qualifying examination administered by the Board.

(c) No license shall be issued to any person until ~~he~~ the person has served as an apprentice as set forth in G.S. 93D-9 for a period of at least one year; provided, that this subsection shall not apply to those persons qualified under G.S. 93D-6 nor to those persons holding masters degrees in Audiology or persons holding doctoral degrees in Audiology from an accredited training program who have undergone 250 hours of supervised activity fitting and selling hearing aids under the direct supervision of a licensed hearing aid dealer approved by the Board, or have met the licensure requirements under Article 22 of Chapter 90 of the General Statutes and have worked full time for one year fitting and selling hearing aids in the office of and under the direct supervision of an otolaryngologist and have participated in 250 hours of Board-supervised, continuing professional education in fitting hearing aids."

SECTION 4. G.S. 93D-11 reads as rewritten:

"**§ 93D-11. Annual fees; failure to pay; expiration of license; occupational instruction courses.**

Every licensed person who engages in the fitting and selling of hearing aids shall pay to the Board an annual license renewal fee in an amount set by the Board, not to exceed ~~one hundred fifty dollars ($150.00). Such~~two hundred fifty dollars ($250.00). The payment shall be made prior to the first day of April in each year. In case of default in payment the license shall expire 30 days after notice by the secretary-treasurer to the

last known address of the licensee by registered mail. The Board may reinstate an expired license upon the showing of good cause for late payment of fees, upon payment of said fees within 60 days after expiration of the license, and upon the further payment of a late penalty of twenty-five dollars ($25.00). After 60 days after the expiration date, the Board may reinstate the license for good cause shown upon application for reinstatement and payment of a late penalty of fifty dollars ($50.00) and the renewal fee. The Board may require all licensees to successfully attend and complete a course or courses of occupational instruction funded, conducted or approved or sponsored by the Board on an annual basis as a condition to any license renewal and evidence of satisfactory attendance and completion of any such course or courses shall be provided the Board by the licensee."

SECTION 5. G.S. 93D-13 reads as rewritten:

"**§ 93D-13. Discipline, suspension, revocation of ~~licenses.~~licenses; records.**

(a) The Board may in its discretion administer the punishment of private reprimand, suspension of license for a fixed period or revocation of license as the case may warrant in their judgment for any violation of the rules and regulations of the Board or for any of the following causes:

~~(1)~~ ~~Habitual drunkenness~~

(2) Gross ~~incompetence~~incompetence.

(3) ~~Knowingly fitting and selling hearing aids while suffering with a contagious or infectious disease~~Inability to perform the functions for which the person is licensed or substantial impairment of the person's ability to perform the functions for which the person is licensed by reason of physical or mental disability.

(4) Commission of a criminal offense indicating professional ~~unfitness~~unfitness.

(5) The use of a false name or alias in ~~his business~~his or her business.

(6) Conduct involving willful ~~deceit~~deceit.

(7) Conduct involving fraud or any other business conduct involving moral ~~turpitude~~turpitude.

(8) Advertising of a character or nature tending to deceive or mislead the ~~public~~public.

(9) Advertising declared to be unethical by the Board or prohibited by the code of ethics established by the ~~Board~~Board.

(10) Permitting another person to use ~~his license,~~his or her license.

(10a) Failure by a licensee to properly supervise an apprentice under ~~his supervision, and~~his or her supervision.

(11) For violating any of the provisions of this Chapter.

(b) Board action in revoking or suspending a license shall be in accordance with Chapter 150B of the General Statutes. Any person whose license has been suspended for any of the grounds or reasons herein set forth, may, after the expiration of 90 days but within two years, apply to the Board to have the same reissued; upon a showing satisfactory to the Board that ~~such~~ reissuance will not endanger the public health and welfare, the Board may reissue a license to such person for a fee set by the Board, not to

exceed two hundred dollars ($200.00). If application is made subsequent to two years from date of suspension, reissuance shall be in accordance with the provisions of G.S. 93D-8.

(c) Records, papers, and other documents containing information collected or compiled by or on behalf of the Board as a result of an investigation, inquiry, or interview conducted in connection with registration, licensure, or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes. Any notice or statement of charges, notice of hearing, or decision rendered by the Board in connection with a hearing is a public record. However, information that identifies a consumer who has not consented to the public disclosure of services rendered to the consumer by a person registered or licensed under this Chapter shall be deleted from the public record. All other records, papers, and documents containing information collected or compiled by or on behalf of the Board shall be public records, provided that any information that identifies a consumer who has not consented to the public disclosure of services rendered to the consumer is deleted."

SECTION 6. This act is effective when it becomes law.

SENATE BILL 1332:
Raise Fee Ceil'g/Amend Hear. Aid Dealer Laws

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	June 20, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker Legislative Analyst
Version:	PCS to First Edition S1332-CSSQf-44		

SUMMARY: ***Senate Bill 1332 authorizes the North Carolina State Hearing Aid Dealers and Fitters Board to increase fees charged for licensure application, renewal, and examination. It also increases the reimbursement rate for Board member travel. The bill further provides that certain information collected as a result of an investigation conducted in connection with registration, licensure, or a disciplinary matter is not public record. It also makes technical changes.***

The Proposed Committee Substitute changes the notice language by authorizing the Board to serve notice of license expiration by registered mail, certified mail or depositing with a designated delivery service.

CURRENT LAW: Persons fitting or selling hearing aids in North Carolina are required to be licensed by the North Carolina State Hearing Aid Dealers and Fitters Board (Board) or be an apprentice under the supervision of a licensee. An applicant for licensure must complete various requirements and pay a fee. Licenses must be renewed annually.

BILL ANALYSIS: Senate Bill 1332 authorizes the Board to raise certain fees and reimbursement rates as follows:

Type of Fee	Old Maximum	New Maximum
Examination fee	$75	$300
Issuance of license	$150	$250
Renewal of license	$150	$250
Type of Reimbursement		
Board member travel, per diem, and other authorized expenses	8¢ per mile Meals/Lodging- Actual rate not to exceed $20	As provided in G.S. 138-6(a) Mileage- 25¢ per mile Subsistence $81 in-State $93 out of State

The bill makes further substantive changes as follows:

Section 2 amends G.S. 93D-3(d) by removing the bonding requirement of the Board's secretary treasurer and by revising the travel reimbursement and reporting requirements.

Section 3 allows persons holding doctoral degrees in Audiology to be issued a license as a hearing aid dealer and fitter without serving as an apprentice for a period of one year.

Section 4 changes the notice language by authorizing the Board to serve notice of license expiration by registered mail, certified mail, or by depositing with a designated delivery service in accordance with G.S. 1A-1, Rule 4(j)(1)d.

Section 5 adds a provision to GS 93D-13 to specify that documents containing information collected by the Board as a result of an investigation or inquiry conducted in connection with registration, licensure, or a disciplinary matter are not a public record. Notice, statement of charges and decisions rendered by the Board in connection with the hearing are public records. Information that identifies a consumer is not public unless the consumer consents to disclosure. The section also provides the Board the discretion to suspend a license for the inability to perform the functions for which a person is licensed.

Section 6 makes the act effective when it becomes law.

EFFECTIVE DATE: This act is effective when it becomes law.

S1332e1-SMSQ-CSSQf-44

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 625*

Committee Substitute Favorable 5/21/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H625-PCS60372-SQ-42

Short Title: Amend MH/DD/SA Statutes/Rename Facilities.-AB (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO RENAME MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FACILITIES AND TO MAKE OTHER CONFORMING AND STATUTORY CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-181(a) reads as rewritten:

"**§ 122C-181. Secretary's jurisdiction over State facilities.**

(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) ~~For the mentally ill:~~Psychiatric Hospitals:
  a. Cherry ~~Hospital;~~Hospital.
  b. Dorothea Dix ~~Hospital;~~ Hospital.
  c. John Umstead ~~Hospital; and~~ Hospital.
  d. Broughton ~~Hospital; and~~Hospital.

(2) ~~For the mentally retarded:~~Developmental Centers:
  a. Caswell ~~Center;~~Developmental Center.
  ~~b. O'Berry Center;~~
  b1. J. Iverson Riddle Developmental Center.
  c. Murdoch ~~Center;~~Developmental Center.
  ~~d. Western Carolina Center; and~~
  ~~e. Black Mountain Center; and~~

(3) ~~For substance abusers:~~Alcohol and Drug Treatment Centers:
  a. Walter B. Jones Alcohol and Drug Abuse Treatment ~~Center at Greenville;~~Center.
  ~~b. Alcohol and Drug Abuse Treatment Center at John Umstead Hospital; and~~

c. Julian F. Keith Alcohol and Drug Abuse Treatment ~~Center; and~~Center.
d. R.J. Blackley Alcohol and Drug Treatment Center.
(4) ~~As special care facilities:~~Neuro-Medical Treatment Centers:
~~a. North Carolina Special Care Center;~~
~~b. Whitaker School; and~~
~~c. Wright School.~~
d. Black Mountain Neuro-Medical Treatment Center.
e. O'Berry Neuro-Medical Treatment Center.
f. Longleaf Neuro-Medical Treatment Center.
(5) Residential Programs for Children:
a. Whitaker School.
b. Wright School."

SECTION 2. G.S. 122C-181(a)(1), as amended by Section 1 of this act, reads as rewritten:

"(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) Psychiatric Hospitals:
a. Cherry Hospital.
a1. Central Regional Hospital.
~~b. Dorothea Dix Hospital.~~
~~c. John Umstead Hospital.~~
d. Broughton Hospital."

SECTION 3. G.S. 122C-430.30 reads as rewritten:

"Part 2A. Broughton Hospital Joint Security Force.

"**§ 122C-430. Joint security force.**

The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department by any other law on the territory of the Broughton Hospital, North Carolina School for the ~~Deaf,~~ Deaf at Morganton (K-12), Western Regional Vocational Rehabilitation Facility, ~~Western Carolina Center,~~ J. Iverson Riddle Developmental Center, and the surrounding grounds and land adjacent to Broughton Hospital allocated to the Department of Agriculture and Consumer Services, all in Burke County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory embraced by the named facilities. These special police officers may arrest persons outside the territory of the named institutions but within the confines of Burke County when the person arrested has committed a criminal offense within that territory for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory."

SECTION 4. G.S. 108A-101(m) reads as rewritten:

"(m) The word "neglect" refers to a disabled adult who is either living alone and not able to provide for himself or herself the services which are necessary to maintain ~~his~~ the person's mental or physical health or is not receiving services from ~~his~~ the person's caretaker. A person is not receiving services from his caretaker if, among other things and not by way of limitation, ~~he~~ the person is a resident of one of the ~~State-owned hospitals for the mentally ill,~~State-owned psychiatric hospitals listed in G.S. 122C-181(a)(1), ~~centers for the mentally retarded or North Carolina Special Care Center~~ the State-owned Developmental Centers listed in G.S. 122C-181(a)(2), or the State-owned Neuro-Medical Treatment Centers listed in G.S. 122C-181(a)(3), ~~he~~ the person is, in the opinion of the professional staff of that ~~hospital or center,~~State-owned facility, mentally incompetent to give ~~his~~ consent to medical treatment, ~~he~~ the person has no legal guardian appointed pursuant to Chapter 35A, or guardian as defined in G.S. 122C-3(15), and ~~he~~ the person needs medical treatment."

SECTION 5. Section 2 of this act becomes effective when the Dorothea Dix Hospital is closed and is no longer serving psychiatric patients. The remainder of this act is effective when it becomes law.

HOUSE BILL 625:
Amend MH/DD/SA Statutes/Rename Facilities.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 15, 2007
Introduced by:	Rep. Insko	**Summary by:**	Shawn Parker
Version:	PCS to Second Edition H625-CSSQ-42		Legislative Analyst

SUMMARY: ***House Bill 625 updates and renames certain State-operated facilities that provide mental health, developmental disabilities, and substance abuse services. It also makes certain conforming changes in the statutes.***

The Senate Proposed Committee Substitute renames the "Wilson Neuro-Medical Treatment Center" to "Longleaf Neuro-Medical Treatment Center".

[As introduced, this bill was identical to S918, as introduced by Sen. Nesbitt, which is currently in Senate Health Care.]

CURRENT LAW: G.S. 122C-181(a) lists the State-operated institutions that provide mental health, developmental disabilities or substance abuse services. Dorothea Dix Hospital and John Umstead Hospital are expected to be closed in early 2008 when the new psychiatric hospital (Central Regional) becomes operational.

BILL ANALYSIS:

Section 1 updates G.S. 122C-181(a) to reflect current terminology and recent name changes for several State-operated facilities.

Section 2 removes the names of the Dorothea Dix Hospital and the John Umstead Hospital and substitutes the Central Regional Hospital.

Sections 3 and 4 make conforming changes elsewhere in the statutes.

EFFECTIVE DATE: The Section related to the closure of Dorothea Dix Hospital (Section 2) becomes effective when the hospital closes and is no longer serving psychiatric patients. The remainder of the act is effective when it becomes law.

H0625e2-SMSQ-CSSQ-42

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 625*

Committee Substitute Favorable 5/21/07

Short Title: Amend MH/DD/SA Statutes/Rename Facilities.-AB (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO RENAME MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FACILITIES, AND TO MAKE OTHER CONFORMING AND STATUTORY CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-181(a) reads as rewritten:

"**§ 122C-181. Secretary's jurisdiction over State facilities.**

(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) ~~For the mentally ill:~~Psychiatric Hospitals:
  a. Cherry ~~Hospital;~~Hospital.
  b. Dorothea Dix ~~Hospital;~~ Hospital.
  c. John Umstead ~~Hospital; and~~ Hospital.
  d. Broughton ~~Hospital; and~~Hospital.

(2) ~~For the mentally retarded:~~Developmental Centers:
  a. Caswell ~~Center;~~Developmental Center.
  ~~b. O'Berry Center;~~
  b1. J. Iverson Riddle Developmental Center.
  c. Murdoch ~~Center;~~Developmental Center.
  ~~d. Western Carolina Center; and~~
  ~~e. Black Mountain Center; and~~

(3) ~~For substance abusers:~~Alcohol and Drug Treatment Centers:
  a. Walter B. Jones Alcohol and Drug Abuse Treatment ~~Center at Greenville;~~Center.
  ~~b. Alcohol and Drug Abuse Treatment Center at John Umstead Hospital; and~~
  c. Julian F. Keith Alcohol and Drug Abuse Treatment ~~Center; and~~Center.
  d. R.J. Blackley Alcohol and Drug Treatment Center.

(4) ~~As special care facilities:~~Neuro-Medical Treatment Centers:
~~a. North Carolina Special Care Center;~~
~~b. Whitaker School; and~~
~~c. Wright School.~~
d. Black Mountain Neuro-Medical Treatment Center.
e. O'Berry Neuro-Medical Treatment Center.
f. Wilson Neuro-Medical Treatment Center.
(5) Residential Programs for Children:
a. Whitaker School.
b. Wright School."

SECTION 2. G.S. 122C-181(a)(1), as amended by Section 1 of this act, reads as rewritten:

"(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) Psychiatric Hospitals:
a. Cherry Hospital.
a1. Central Regional Hospital.
~~b. Dorothea Dix Hospital.~~
~~c. John Umstead Hospital.~~
d. Broughton Hospital."

SECTION 3. G.S. 122C-430.30 reads as rewritten:

"Part 2A. Broughton Hospital Joint Security Force.

"**§ 122C-430. Joint security force.**

The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department by any other law on the territory of the Broughton Hospital, North Carolina School for the ~~Deaf,~~ Deaf at Morganton (K-12), Western Regional Vocational Rehabilitation Facility, ~~Western Carolina Center,~~ J. Iverson Riddle Developmental Center, and the surrounding grounds and land adjacent to Broughton Hospital allocated to the Department of Agriculture and Consumer Services, all in Burke County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory embraced by the named facilities. These special police officers may arrest persons outside the territory of the named institutions but within the confines of Burke County when the person arrested has committed a criminal offense within that territory for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory."

SECTION 4. G.S. 108A-101(m) reads as rewritten:

"(m) The word "neglect" refers to a disabled adult who is either living alone and not able to provide for himself or herself the services which are necessary to maintain ~~his~~ the person's mental or physical health or is not receiving services from ~~his~~ the person's caretaker. A person is not receiving services from his caretaker if, among other

things and not by way of limitation, ~~he~~ the person is a resident of one of the ~~State-owned hospitals for the mentally ill,~~State-owned psychiatric hospitals listed in G.S. 122C-181(a)(1), ~~centers for the mentally retarded or North Carolina Special Care Center~~ the State-owned Developmental Centers listed in G.S. 181(a)(2), or the State-owned Neuro-Medical Treatment Centers listed in G.S. 122C-181(a)(3), ~~he~~ the person is, in the opinion of the professional staff of that ~~hospital or center,~~State-owned facility, mentally incompetent to give ~~his~~ consent to medical treatment, ~~he~~ the person has no legal guardian appointed pursuant to Chapter 35A, or guardian as defined in G.S. 122C-3(15), and ~~he~~ the person needs medical treatment."

SECTION 5. Section 2 of this act becomes effective when the Dorothea Dix Hospital is closed and is no longer serving psychiatric patients. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1372

Committee Substitute Favorable 5/2/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1372-PCS30499-RC-50

Short Title: Organ & Tissue Donation/The Heart Prevails. (Public)

Sponsors:

Referred to:

April 10, 2007

A BILL TO BE ENTITLED

AN ACT TO ENACT THE REVISED UNIFORM ANATOMICAL GIFT ACT; TO PROVIDE THAT THE DECISION TO HAVE THE HEART SYMBOL ON ONE'S DRIVERS LICENSE IS LEGALLY SUFFICIENT CONSENT TO ORGAN DONATION UNLESS REVOKED BY THE DONOR; TO IMPROVE DONOR OR PROSPECTIVE DONOR ONLINE ACCESS TO INDICATE OR REVOKE ORGAN AND TISSUE DONATION; AND TO MAKE CONFORMING CHANGES TO OTHER AFFECTED GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 16 of Chapter 130A of the General Statutes is amended by adding the following new Part to read:

"Part 3A. Revised Uniform Anatomical Gift Act.

"**§ 130A-412.3. Short title.**

This Part may be cited as the Revised Uniform Anatomical Gift Act.

"**§ 130A-412.4. Definitions.**

The following definitions apply in this Part:

(1) "Adult" means an individual who is at least 18 years of age.

(1a) "Advanced directive" includes all of the following:

a. A health care power of attorney under G.S. 32A-16.

b. A record signed or authorized by a prospective donor containing the prospective donor's direction concerning a health care decision for the prospective donor.

c. A declaration of a desire for a natural death as provided under Article 23 of Chapter 90 of the General Statutes.

(2) "Agent" means an individual:

a. Authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

b. Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

(4) "Body part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

(5) "Decedent" means a deceased individual whose body or body part is or may be the source of an anatomical gift. The term includes a stillborn infant and, subject to restrictions imposed by law other than this Article, a fetus.

(6) "Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to whom an anatomical gift could pass under G.S. 130A-412.13.

(7) "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a drivers license, identification card, or donor registry.

(8) "Donor" means an individual whose body or body part is the subject of an anatomical gift.

(9) "Donor registry" means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.

(10) "Drivers license" means a license or permit issued by the North Carolina Department of Transportation, Division of Motor Vehicles, to operate a vehicle, whether or not conditions are attached to the license or permit.

(11) "Eye bank" means an entity that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.

(12) "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.

(12a) "Health care decision" means any decision made regarding the health care of the prospective donor.

(13) "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

(14) "Identification card" means an identification card issued by the North Carolina Department of Transportation, Division of Motor Vehicles.

(15) "Know" means to have actual knowledge.

(16) "Minor" means an individual who is under 18 years of age.

(17) "Organ procurement organization" means a person designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization.

(18) "Parent" means a parent whose parental rights have not been terminated.

(19) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(20) "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

(21) "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

(22) "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a body part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

(23) "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

(24) "Recipient" means an individual into whose body a decedent's body part has been or is intended to be transplanted.

(25) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(26) "Refusal" means a record created under G.S. 130A-412.9 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or body part.

(27) "Sign" means, with the present intent to authenticate or adopt a record:

a. To execute or adopt a tangible symbol; or

b. To attach to or logically associate with the record an electronic symbol, sound, or process.

(28) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(29) "Technician" means an individual determined to be qualified to remove or process body parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an enucleator.

(30) "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

(31) "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

(32) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

"**§ 130A-412.5. Applicability.**

This act applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

"**§ 130A-412.6. Who may make an anatomical gift before donor's death.**

Subject to G.S. 130A-412.10, an anatomical gift of a donor's body or body part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in G.S. 130A-412.7 by:

(1) The donor, if the donor is an adult or if the donor is a minor and is:

a. Emancipated; or

b. Authorized under State law to apply for a drivers license because the donor is at least 16 years of age;

(2) An agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(3) A parent of the donor, if the donor is an unemancipated minor; or

(4) The donor's guardian.

"**§ 130A-412.7. Manner of making anatomical gift before donor's death.**

(a) A donor may make an anatomical gift by any of the following methods:

(1) By authorizing that a statement or symbol be imprinted on the donor's drivers license or identification card indicating that the donor has made an anatomical gift. Anatomical gifts made by this method shall not include a donation of tissue or the donor's body.

(2) In a will.

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

(4) As provided in subsection (b) of this section.

(b) A donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) Revocation, suspension, expiration, or cancellation of a drivers license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(d) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

"**§ 130A-412.8. Amending or revoking anatomical gift before donor's death.**

(a) Subject to G.S. 130A-412.10, a donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may amend or revoke an anatomical gift by:

(1) A record signed by:

a. The donor;

b. The other person; or

c. Subject to subsection (b) of this section, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(2) A later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

(b) A record signed pursuant to sub-subdivision c. of subdivision (1) of subsection (a) of this section must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) Subject to G.S. 130A-412.10, a donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(d) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(e) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection (a) of this section.

"**§ 130A-412.9. Refusal to make anatomical gift; effect of refusal.**

(a) An individual may refuse to make an anatomical gift of the individual's body or body part by:

(1) A record signed by:

a. The individual; or

b. Subject to subsection (b) of this section, another individual acting at the direction of the individual if the individual is physically unable to sign;

(2) The individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(3) Any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(b) A record signed pursuant to sub-subdivision b. of subdivision (1) of subsection (a) of this section must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) An individual who has made a refusal may amend or revoke the refusal:

(1) In the manner provided in subsection (a) of this section for making a refusal;

(2) By subsequently making an anatomical gift pursuant to G.S. 130A-412.7 that is inconsistent with the refusal; or

(3) By destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(d) Except as otherwise provided in G.S. 130A-412.10(h), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or body part bars all other persons from making an anatomical gift of the individual's body or body part.

"**§ 130A-412.10. Preclusive effect of an anatomical gift, amendment, or revocation.**

(a) Except as otherwise provided in subsection (g) of this section and subject to subsection (f) of this section, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or body part if the donor made an anatomical gift of the donor's body or body part under G.S. 130A-412.7 or an amendment to an anatomical gift of the donor's body or body part under G.S. 130A-412.8.

(b) A donor's revocation of an anatomical gift of the donor's body or body part under G.S. 130A-412.8 is not a refusal and does not bar another person specified in G.S. 130A-412.6 or G.S. 130A-412.11 from making an anatomical gift of the donor's body or body part under G.S. 130A-412.7 or G.S. 130A-412.12.

(c) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or body part under G.S. 130A-412.7 or an amendment to an anatomical gift of the donor's body or body part under G.S. 130A-412.8, another person may not make, amend, or revoke the gift of the donor's body or body part under G.S. 130A-412.12.

(d) A revocation of an anatomical gift of a donor's body or body part under G.S. 130A-412.8 by a person other than the donor does not bar another person from making an anatomical gift of the body or body part under G.S. 130A-412.7 or G.S. 130A-412.12.

(e) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under G.S. 130A-412.6, an anatomical gift of a body part is neither a refusal to give another body part nor a limitation on the making of an anatomical gift of another body part at a later time by the donor or another person.

(f) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under G.S. 130A-412.6, an anatomical gift of a body part for one or more of the purposes set forth in G.S. 130A-412.6 is not a limitation on the making of an anatomical gift of the body part for any of the other purposes by the donor or any other person under G.S. 130A-412.7 or G.S. 130A-412.12.

(g) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or body part.

(h) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

"**§ 130A-412.11. Who may make an anatomical gift of decedent's body or body part.**

(a) Subject to subsections (b) and (c) of this section, and unless barred by G.S. 130A-412.9 or G.S. 130A-412.10, an anatomical gift of a decedent's body or body part for purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(1) An agent of the decedent at the time of death who could have made an anatomical gift under G.S. 130A-412.6(2) immediately before the decedent's death;

(2) The spouse of the decedent;

(3) Adult children of the decedent;

(4) Parents of the decedent;

(5) Adult siblings of the decedent;

(6) Adult grandchildren of the decedent;

(7) Grandparents of the decedent;

(8) An adult who exhibited special care and concern for the decedent;

(9) The persons who were acting as the guardians of the person of the decedent at the time of death; and

(10) Any other person having the authority to dispose of the decedent's body.

(b) If there is more than one member of a class listed in subsection (a)(1), (3), (4), (5), (6), (7), or (9) of this section entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under G.S. 130A-412.13 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(c) A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection (a) of this section is reasonably available to make or to object to the making of an anatomical gift.

"§ 130A-412.12. Manner of making, amending, or revoking anatomical gift of decedent's body or body part.

(a) A person authorized to make an anatomical gift under G.S. 130A-412.11 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(b) Subject to subsection (c) of this section, an anatomical gift by a person authorized under G.S. 130A-412.11 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under G.S. 130A-412.11 may be:

(1) Amended only if a majority of the reasonably available members agrees to the amending of the gift; or

(2) Revoked only if a majority of the reasonably available members agrees to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(c) A revocation under subsection (b) of this section is effective only if, before an incision has been made to remove a body part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

"§ 130A-412.13. Persons that may receive anatomical gift; purpose of anatomical gift.

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) A hospital; accredited medical school, dental school, college, or university; organ procurement organization; or other appropriate person, for research or education;

(2) Subject to subsection (b) of this section, an individual designated by the person making the anatomical gift if the individual is the recipient of the body part;

(3) An eye bank or tissue bank.

(b) If an anatomical gift to an individual under subsection (a)(2) of this section cannot be transplanted into the individual, the body part passes in accordance with subsection (g) of this section in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific body parts or of all body parts is made in a document of gift that does not name a person described in subsection (a) of this section but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) If the body part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

(2) If the body part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

(3) If the body part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(4) If the body part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of subsection (c) of this section, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific body parts is made in a document of gift that does not name a person described in subsection (a) of this section and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g) of this section.

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g) of this section.

(g) For purposes of subsections (b), (e), and (f) of this section, the following rules apply:

(1) If the body part is an eye, the gift passes to the appropriate eye bank.

(2) If the body part is tissue, the gift passes to the appropriate tissue bank.

(3) If the body part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under subdivision (a)(2) of this section, passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to subsections (a) through (h) of this section or the decedent's body or body part is not used for transplantation, therapy, research, or education, then custody of the body or body part passes to the person under obligation to dispose of the body or body part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under G.S. 130A-412.7 or G.S. 130A-412.12 or if the person knows that the decedent made a refusal under G.S. 130A-412.9 that was not revoked. For purposes of the subsection, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in subdivision (a)(2) of this section, nothing in this act affects the allocation of organs for transplantation or therapy.

"§ 130A-412.14. Search and notification.

(a) The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) A law enforcement officer, firefighter, paramedic, or other emergency rescuer finding the individual; and

(2) If no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

(b) If a document of gift or a refusal to make an anatomical gift is located by the search required by subdivision (a)(1) of this section and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

(c) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

"§ 130A-412.15. Delivery of document of gift not required; right to examine.

(a) A document of gift need not be delivered during the donor's lifetime to be effective.

(b) Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under G.S. 130A-412.13.

"§ 130A-412.16. Rights and duties of procurement organization and others.

(a) When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the North Carolina Department of Transportation, Division of Motor Vehicles, and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

(b) A procurement organization must be allowed reasonable access to information in the records of the North Carolina Department of Transportation, Division of Motor Vehicles, to ascertain whether an individual at or near death is a donor.

(c) When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a body part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the body part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(d) Unless prohibited by law other than this Part, at any time after a donor's death, the person to which a body part passes under G.S. 130A-412.13 may conduct any reasonable examination necessary to ensure the medical suitability of the body or body part for its intended purpose.

(e) Unless otherwise prohibited by law, an examination under subsection (c) or (d) of this section may include an examination of all medical and dental records of the donor or prospective donor.

(f) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(g) Upon referral by a hospital under subsection (a) of this section, a procurement organization shall make a reasonable search for any person listed in G.S. 130A-412.11 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

(h) Subject to G.S. 130A-412.13(i) and G.S. 130A-412.25, the rights of the person to which a body part passes under G.S. 130A-412.13 are superior to the rights of all others with respect to the body part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and this Part, a person that accepts an anatomical gift of an entire body may allow embalming, burial, or cremation, and use of remains in a funeral service. If the gift is of a body part, the person to which the body part passes under G.S. 130A-412.13, upon the death of the donor and before embalming, burial, or cremation, shall cause the body part to be removed without unnecessary mutilation.

(i) Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

(j) A physician or technician may remove a donated body part from the body of a donor that the physician or technician is qualified to remove.

"**§ 130A-412.17. Coordination of procurement and use.**

Each hospital in this State shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

"**§ 130A-412.18. Sale or purchase of body parts prohibited.**

(a) Except as otherwise provided in subsection (b) of this section, a person, that for valuable consideration, knowingly purchases or sells a body part for transplantation or therapy if removal of a body part from an individual is intended to occur after the individual's death commits a Class H felony and upon conviction is subject to a fine not exceeding fifty thousand dollars ($50,000) or imprisonment not exceeding five years, or both.

(b) A person may charge a reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a body part.

"**§ 130A-412.19. Other prohibited acts.**

A person that, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces, or obliterates a document of gift, an amendment or revocation of a

document of gift, or a refusal commits a Class H felony and upon conviction is subject to a fine not exceeding fifty thousand dollars ($50,000) or imprisonment not exceeding five years, or both.

"**§ 130A-412.20. Immunity.**

(a) A person that acts with due care in accordance with this Part or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

(b) Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

(c) In determining whether an anatomical gift has been made, amended, or revoked under this Part, a person may rely upon representations of an individual listed in subdivisions (2) through (8) of G.S. 130A-412.11(a) relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

"**§ 130A-412.21. Law governing validity; choice of law as to execution of document of gift; presumption of validity.**

(a) A document of gift is valid if executed in accordance with:

(1) This Part;

(2) The laws of the state or country where it was executed; or

(3) The laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

(b) If a document of gift is valid under this section, the law of this State governs the interpretation of the document of gift.

(c) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

"**§ 130A-412.22. Donor registry.**

The online Organ Donor Registry Internet site established pursuant to G.S. 20-43.2 shall be the State donor registry for anatomical gifts made pursuant to this Part. Requirements for maintenance and use of the State donor registry shall be as provided under G.S. 20-43.2.

"**§ 130A-412.23. Effect of anatomical gift on advanced directive.**

If a prospective donor has a declaration or advanced health care directive, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor unless the declaration expressly provides to the contrary.

"**§ 130A-412.24. Cooperation between a medical examiner and the procurement organization.**

(a) The medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

(b) If a medical examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose

body is under the jurisdiction of the medical examiner and a postmortem examination is going to be performed, unless the medical examiner denies recovery in accordance with G.S. 130A-412.25, the medical examiner or designee shall conduct a postmortem examination of the body or the body part in a manner and within a period compatible with its preservation for the purposes of the gift.

(c) A body part may not be removed from the body of a decedent under the jurisdiction of a medical examiner for transplantation, therapy, research, or education unless the body part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This subsection does not preclude a medical examiner from performing the medicolegal investigation upon the body or body parts of a decedent under the jurisdiction of the medical examiner.

(d) As used in this section and G.S. 130A-412.25, "medical examiner" includes the Chief Medical Examiner, a county medical examiner, or a designee of either.

"**§ 130A-412.25. Facilitation of anatomical gift from decedent whose body is under the jurisdiction of a medical examiner.**

(a) Upon request of a procurement organization, a medical examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is or will come under the jurisdiction of the medical examiner. If the decedent's body or body part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the postmortem examination results or other information received from the medical examiner only if relevant to transplantation or therapy.

(b) The medical examiner may conduct a medicolegal examination including physical examination of a donor or prospective donor and review of all medical records, laboratory test results, X-rays, other diagnostic results, and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the medical examiner or whose body would be under the medical examiner's jurisdiction upon death and that the medical examiner determines may be relevant to the investigation.

(c) A person that has any information requested by a medical examiner pursuant to subsection (b) of this section shall provide that information as expeditiously as possible to allow the medical examiner to conduct the medicolegal investigation within a period compatible with the preservation of body parts for the purpose of transplantation, therapy, research, or education.

(d) If an anatomical gift has been or might be made of a body part of a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is not required, or the medical examiner determines that a postmortem examination is required but that the recovery of the body part that is the subject of an anatomical gift will not interfere with the examination, the medical examiner and procurement organization shall cooperate in the timely removal of the body part from the decedent for the purpose of transplantation, therapy, research, or education.

(e) If an anatomical gift of a body part from the decedent under the jurisdiction of the medical examiner has been or might be made, but the medical examiner initially believes that the recovery of the body part could interfere with the postmortem investigation into the decedent's cause or manner of death, the collection of evidence, or the description, documentation, or interpretation of injuries on the body, the medical examiner shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the medical examiner may deny or allow the recovery.

(f) If the medical examiner or designee allows recovery of a body part under subsection (d) or (e) of this section, the procurement organization shall provide the medical examiner or designee with a record describing the condition of the body part signed by the physician or technician who removes the body part and any other information and observations that would assist in the postmortem examination."

SECTION 2. G.S. 20-43.2 reads as rewritten:

"**§ 20-43.2. Internet access to organ donation records by organ procurement organizations.**

(a) The Department of Transportation, Division of Motor Vehicles, shall establish and maintain a statewide, online Organ Donor Registry Internet ~~site.~~site (hereafter "Donor Registry"). The purpose of the ~~Organ Donor Internet site~~ Donor Registry is to enable federally designated organ procurement organizations and eye banks to have ~~timely access to~~access 24 hours per day, seven days per week to obtain relevant information on the Donor Registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift through a symbol on the donor's or prospective donor's drivers license, special identification card, or other manner. ~~the names of individuals who have stated to the Division the individual's intent to be an organ donor and have an organ donation symbol on the individual's drivers license or special identification card.~~ The data available on the ~~Organ Donor Internet site~~ Donor Registry shall be limited to the individual's first, middle, and last name, date of birth, address, sex, county of residence, and drivers license number. The Division of Motor Vehicles shall ensure that only federally designated organ procurement organizations and eye banks operating in this State have access to the ~~Organ Donor Internet site~~Donor Registry in read-only format. The Division of Motor Vehicles shall enable federally designated organ procurement organizations and eye banks operating in this State to have online access in read-only format to the ~~Organ Donor Internet site~~Donor Registry through a unique identifier and password issued to the organ procurement organization or eye bank by the Division of Motor Vehicles. ~~The read-only information from the Organ Donor Internet site will be used for the sole purpose of seeking consent from the individual's next of kin for organ, tissue, or eye donation.~~Employees of the Division who provide access to or disclosure of information in good-faith compliance with this section are not liable in damages for access to or disclosure of the information.

(b) When accessing and using information obtained from the ~~Organ Donor Internet site,~~Donor Registry, federally designated organ procurement organizations and

eye banks shall comply with the requirements of Part ~~3~~3A of Article 16 of Chapter 130A of the General Statutes.

(c) Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor, or person that made the anatomical gift for any purpose other than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift.

(d) This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the State. Any such registry must comply with subsections (b) and (c) of this section."

SECTION 3. The North Carolina Department of Transportation, Division of Motor Vehicles, in cooperation with the License to Give Trust Fund Commission, shall use available grant-in-aid funds from the State and federal governments and other sources to enhance online access such that donors and prospective donors may update, amend, or revoke information on the donor's or prospective donor's drivers license or donor card.

SECTION 4. This act modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001, et seq., but does not modify, limit, or supersede Section 101(a) of that act, 15 U.S.C. § 7001, or authorize electronic delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. § 7003(b).

SECTION 5.(a) G.S. 130A-410, 130A-411, 130A-412, 130A-412.1, and 130A-412.2 are recodified under Part 3A of Article 16 of Chapter 130A of the General Statutes, as enacted by this act, as G.S. 130A-412.26, 130A-412.27, 130A-412.28, 130A-412.29, and 130A-412.30 respectively.

SECTION 5.(b) Except as provided in subsection (a) of this section, Part 3 of Article 16 of Chapter 130A of the General Statutes is repealed.

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1372
Committee Substitute Favorable 5/2/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H1372-CSRC-50 [v.2]

6/19/2007 6:00:57 PM

Short Title: Organ & Tissue Donation/the Heart Prevails. (Public)

Sponsors:

Referred to:

April 10, 2007

A BILL TO BE ENTITLED

AN ACT TO ENACT THE REVISED UNIFORM ANATOMICAL GIFT ACT; TO PROVIDE THAT THE DECISION TO HAVE THE HEART SYMBOL ON ONE'S DRIVERS LICENSE IS LEGALLY SUFFICIENT CONSENT TO ORGAN DONATION UNLESS REVOKED BY THE DONOR; TO IMPROVE DONOR OR PROSPECTIVE DONOR ONLINE ACCESS TO INDICATE OR REVOKE ORGAN AND TISSUE DONATION; AND TO MAKE CONFORMING CHANGES TO OTHER AFFECTED GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 16 of Chapter 130A of the General Statutes is amended by adding the following new Part to read:

"Part 3A. Revised Uniform Anatomical Gift Act.

"**§ 130A-412.3. Short title.**

This Part may be cited as the Revised Uniform Anatomical Gift Act.

"**§ 130A-412.4. Definitions.**

The following definitions apply in this Part.

(1) "Adult" means an individual who is at least 18 years of age.

(1a) "Advanced directive." – Includes all of the following:

a. A health care power of attorney under G.S. 32A-16.

b. A record signed or authorized by a prospective donor containing the prospective donor's direction concerning a health care decision for the prospective donor.

c. A declaration of a desire for a natural death as provided under Article 23 of Chapter 90 of the General Statutes.

(3) "Health care decision." – Any decision made regarding the health care of the prospective donor.

(2) "Agent" means an individual:

a. Authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

b. Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

(4) "Body part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

(5) "Decedent" means a deceased individual whose body or body part is or may be the source of an anatomical gift. The term includes a stillborn infant and, subject to restrictions imposed by law other than this Article, a fetus.

(6) "Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to whom an anatomical gift could pass under G.S. 130A-412.13.

(7) "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a drivers license, identification card, or donor registry.

(8) "Donor" means an individual whose body or body part is the subject of an anatomical gift.

(9) "Donor registry" means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.

(10) "Drivers license" means a license or permit issued by the North Carolina Department of Transportation, Division of Motor Vehicles, to operate a vehicle, whether or not conditions are attached to the license or permit.

(11) "Eye bank" means an entity that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.

(12) "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.

(13) "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

(14) "Identification card" means an identification card issued by the North Carolina Department of Transportation, Division of Motor Vehicles.

(15) "Know" means to have actual knowledge.

(16) "Minor" means an individual who is under 18 years of age.

(17) "Organ procurement organization" means a person designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization.

(18) "Parent" means a parent whose parental rights have not been terminated.

(19) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(20) "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

(21) "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

(22) "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a body part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

(23) "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

(24) "Recipient" means an individual into whose body a decedent's body part has been or is intended to be transplanted.

(25) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(26) "Refusal" means a record created under G.S. 130A-412.9 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or body part.

(27) "Sign" means, with the present intent to authenticate or adopt a record:

a. To execute or adopt a tangible symbol; or

b. To attach to or logically associate with the record an electronic symbol, sound, or process.

(28) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(29) "Technician" means an individual determined to be qualified to remove or process body parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an enucleator.

(30) "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

(31) "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

(32) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

"**§ 130A-412.5. Applicability.**

This act applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

"**§ 130A-412.6. Who may make an anatomical gift before donor's death.**

Subject to G.S. 130A-412.10, an anatomical gift of a donor's body or body part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in G.S. 130A-412.7 by:

(1) The donor, if the donor is an adult or if the donor is a minor and is:

a. Emancipated; or

b. Authorized under State law to apply for a drivers license because the donor is at least 16 years of age;

(2) An agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(3) A parent of the donor, if the donor is an unemancipated minor; or

(4) The donor's guardian.

"**§ 130A-412.7. Manner of making anatomical gift before donor's death.**

(a) A donor may make an anatomical gift by any of the following methods:

(1) By authorizing a statement or symbol be imprinted on the donor's drivers license or identification card indicating that the donor has made an anatomical gift. Anatomical gifts made by this method shall not include a donation of tissue or the donor's body.

(2) In a will.

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

(4) As provided in subsection (b) of this section.

(b) A donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) Revocation, suspension, expiration, or cancellation of a drivers license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(d) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

"**§ 130A-412.8. Amending or revoking anatomical gift before donor's death.**

(a) Subject to G.S. 130A-412.10, a donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may amend or revoke an anatomical gift by:

(1) A record signed by:

a. The donor;

b. The other person; or

c. Subject to subsection (b) of this section, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(2) A later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

(b) A record signed pursuant to sub-subdivision c. of subdivision (1) of subsection (a) of this section must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) Subject to G.S. 130A-412.10, a donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(d) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(e) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection (a) of this section.

"**§ 130A-412.9. Refusal to make anatomical gift; effect of refusal.**

(a) An individual may refuse to make an anatomical gift of the individual's body or body part by:

(1) A record signed by:

a. The individual; or

b. Subject to subsection (b) of this section, another individual acting at the direction of the individual if the individual is physically unable to sign;

(2) The individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(3) Any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(b) A record signed pursuant to sub-subdivision b. of subdivision (1) of subsection (a) of this section must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) An individual who has made a refusal may amend or revoke the refusal:

(1) In the manner provided in subsection (a) of this section for making a refusal;

(2) By subsequently making an anatomical gift pursuant to G.S. 130A-412.7 that is inconsistent with the refusal; or

(3) By destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(d) Except as otherwise provided in G.S. 130A-412.10(h), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or body part bars all other persons from making an anatomical gift of the individual's body or body part.

"**§ 130A-412.10. Preclusive effect of an anatomical gift, amendment, or revocation.**

(a) Except as otherwise provided in subsection (g) of this section and subject to subsection (f) of this section, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or body part if the donor made an anatomical gift of the donor's body or body part under G.S. 130A-412.7 or an amendment to an anatomical gift of the donor's body or body part under G.S. 130A-412.8.

(b) A donor's revocation of an anatomical gift of the donor's body or body part under G.S. 130A-412.8 is not a refusal and does not bar another person specified in G.S. 130A-412.6 or G.S. 130A-412.11 from making an anatomical gift of the donor's body or body part under G.S. 130A-412.7 or G.S. 130A-412.12.

(c) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or body part under G.S. 130A-412.7 or an amendment to an anatomical gift of the donor's body or body part under G.S. 130A-412.8, another person may not make, amend, or revoke the gift of the donor's body or body part under G.S. 130A-412.12.

(d) A revocation of an anatomical gift of a donor's body or body part under G.S. 130A-412.8 by a person other than the donor does not bar another person from making an anatomical gift of the body or body part under G.S. 130A-412.7 or G.S. 130A-412.12.

(e) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under G.S. 130A-412.6, an anatomical gift of a body part is neither a refusal to give another body part nor a limitation on the making of an anatomical gift of another body part at a later time by the donor or another person.

(f) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under G.S. 130A-412.6, an anatomical gift of a body part for one or more of the purposes set forth in G.S. 130A-412.6 is not a limitation on the making of an anatomical gift of the body part for any of the other purposes by the donor or any other person under G.S. 130A-412.7 or G.S. 130A-412.12.

(g) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or body part.

(h) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

"**§ 130A-412.11. Who may make an anatomical gift of decedent's body or body part.**

(a) Subject to subsections (b) and (c) of this section, and unless barred by G.S. 130A-412.9 or G.S. 130A-412.10, an anatomical gift of a decedent's body or body part for purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(1) An agent of the decedent at the time of death who could have made an anatomical gift under G.S. 130A-412.6(2) immediately before the decedent's death;

(2) The spouse of the decedent;

(3) Adult children of the decedent;

(4) Parents of the decedent;

(5) Adult siblings of the decedent;

(6) Adult grandchildren of the decedent;

(7) Grandparents of the decedent;

(8) An adult who exhibited special care and concern for the decedent;

(9) The persons who were acting as the guardians of the person of the decedent at the time of death; and

(10) Any other person having the authority to dispose of the decedent's body.

(b) If there is more than one member of a class listed in subsection (a)(1), (3), (4), (5), (6), (7), or (9) of this section entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under G.S. 130A-412.13 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(c) A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection (a) of this section is reasonably available to make or to object to the making of an anatomical gift.

"**§ 130A-412.12. Manner of making, amending, or revoking anatomical gift of decedent's body or body part.**

(a) A person authorized to make an anatomical gift under G.S. 130A-412.11 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(b) Subject to subsection (c) of this section, an anatomical gift by a person authorized under G.S. 130A-412.11 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under G.S. 130A-412.11 may be:

(1) Amended only if a majority of the reasonably available members agrees to the amending of the gift; or

(2) Revoked only if a majority of the reasonably available members agrees to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(c) A revocation under subsection (b) of this section is effective only if, before an incision has been made to remove a body part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

"**§ 130A-412.13. Persons that may receive anatomical gift; purpose of anatomical gift.**

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) A hospital; accredited medical school, dental school, college, or university; organ procurement organization; or other appropriate person, for research or education;

(2) Subject to subsection (b) of this section, an individual designated by the person making the anatomical gift if the individual is the recipient of the body part;

(3) An eye bank or tissue bank.

(b) If an anatomical gift to an individual under subsection (a)(2) of this section cannot be transplanted into the individual, the body part passes in accordance with subsection (g) of this section in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific body parts or of all body parts is made in a document of gift that does not name a person described in subsection (a) of this section but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) If the body part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

(2) If the body part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

(3) If the body part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(4) If the body part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of subsection (c) of this section, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific body parts is made in a document of gift that does not name a person described in subsection (a) of this section and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g) of this section.

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g) of this section.

(g) For purposes of subsections (b), (e), and (f) of this section the following rules apply:

(1) If the body part is an eye, the gift passes to the appropriate eye bank.

(2) If the body part is tissue, the gift passes to the appropriate tissue bank.

(3) If the body part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under subsection (a)(2) of this section, passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to subsections (a) through (h) of this section or the decedent's body or body part is not used for transplantation, therapy, research, or education, then custody of the body or body part passes to the person under obligation to dispose of the body or body part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under G.S. 130A-412.7 or G.S. 130A-412.12 or if the person knows that the decedent made a refusal under G.S. 130A-412.9 that was not revoked. For purposes of the subsection, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in subdivision (a)(2) of this section, nothing in this act affects the allocation of organs for transplantation or therapy.

"**§ 130A-412.14. Search and notification.**

(a) The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) A law enforcement officer, firefighter, paramedic, or other emergency rescuer finding the individual; and

(2) If no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

(b) If a document of gift or a refusal to make an anatomical gift is located by the search required by subdivision (a)(1) of this section and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

(c) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

"**§ 130A-412.15. Delivery of document of gift not required; right to examine.**

(a) A document of gift need not be delivered during the donor's lifetime to be effective.

(b) Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under G.S. 130A-412.13.

"**§ 130A-412.16. Rights and duties of procurement organization and others.**

(a) When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the North Carolina Department of Transportation, Division of Motor Vehicles, and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

(b) A procurement organization must be allowed reasonable access to information in the records of the North Carolina Department of Transportation, Division of Motor Vehicles, to ascertain whether an individual at or near death is a donor.

(c) When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a body part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the body part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(d) Unless prohibited by law other than this Part, at any time after a donor's death, the person to which a body part passes under G.S. 130A-412.13 may conduct any reasonable examination necessary to ensure the medical suitability of the body or body part for its intended purpose.

(e) Unless otherwise prohibited by law, an examination under subsection (c) or (d) of this section may include an examination of all medical and dental records of the donor or prospective donor.

(f) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(g) Upon referral by a hospital under subsection (a) of this section, a procurement organization shall make a reasonable search for any person listed in G.S. 130A-412.11 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

(h) Subject to G.S. 130A-412.13(i) and G.S. 130A-412.25, the rights of the person to which a body part passes under G.S. 130A-412.13 are superior to the rights of all others with respect to the body part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and this Part, a person that accepts an anatomical gift of an entire body may allow embalming, burial, or cremation and use of remains in a funeral service. If the gift is of a body part, the person to which the body part passes under G.S. 130A-412.13, upon the death of the donor and before embalming, burial, or cremation, shall cause the body part to be removed without unnecessary mutilation.

(i) Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

(j) A physician or technician may remove a donated body part from the body of a donor that the physician or technician is qualified to remove.

"**§ 130A-412.17. Coordination of procurement and use.**

Each hospital in this State shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

"**§ 130A-412.18. Sale or purchase of body parts prohibited.**

(a) Except as otherwise provided in subsection (b) of this section, a person, that for valuable consideration, knowingly purchases or sells a body part for transplantation or therapy if removal of a body part from an individual is intended to occur after the individual's death commits a Class H felony and upon conviction is subject to a fine not exceeding fifty thousand dollars ($50,000) or imprisonment not exceeding five years, or both.

(b) A person may charge a reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a body part.

"**§ 130A-412.19. Other prohibited acts.**

A person that, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces, or obliterates a document of gift, an amendment or revocation of a

document of gift, or a refusal commits a Class H felony and upon conviction is subject to a fine not exceeding fifty thousand dollars ($50,000) or imprisonment not exceeding five years, or both.

"**§ 130A-412.20. Immunity.**

(a) A person that acts with due care in accordance with this Part or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

(b) Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

(c) In determining whether an anatomical gift has been made, amended, or revoked under this Part, a person may rely upon representations of an individual listed in subdivisions (2) through (8) of G.S. 130A-412.11(a) relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

"**§ 130A-412.21. Law governing validity; choice of law as to execution of document of gift; presumption of validity.**

(a) A document of gift is valid if executed in accordance with:

(1) This Part;

(2) The laws of the state or country where it was executed; or

(3) The laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

(b) If a document of gift is valid under this section, the law of this State governs the interpretation of the document of gift.

(c) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

"**§ 130A-412.22. Donor registry.**

The online Organ Donor Registry Internet site established pursuant to G.S. 20-43.2 shall be the State donor registry for anatomical gifts made pursuant to this Part. Requirements for maintenance and use of the State donor registry shall be as provided under G.S. 20-43.2.

"**§ 130A-412.23. Effect of anatomical gift on advanced directive.**

If a prospective donor has a declaration or advanced health care directive, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor unless the declaration expressly provides to the contrary.

"**§ 130A-412.24. Cooperation between a medical examiner and the procurement organization.**

(a) The medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

(b) If a medical examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose

body is under the jurisdiction of the medical examiner and a postmortem examination is going to be performed, unless the medical examiner denies recovery in accordance with G.S. 130A-412.25, the medical examiner or designee shall conduct a postmortem examination of the body or the body part in a manner and within a period compatible with its preservation for the purposes of the gift.

(c) A body part may not be removed from the body of a decedent under the jurisdiction of a medical examiner for transplantation, therapy, research, or education unless the body part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This subsection does not preclude a medical examiner from performing the medicolegal investigation upon the body or body parts of a decedent under the jurisdiction of the medical examiner.

(d) As used in this section and G.S. 130A-412.25, 'medical examiner' includes the Chief Medical Examiner, a county medical examiner, or a designee of either.

"**§ 130A-412.25. Facilitation of anatomical gift from decedent whose body is under the jurisdiction of a medical examiner.**

(a) Upon request of a procurement organization, a medical examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is or will come under the jurisdiction of the medical examiner. If the decedent's body or body part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the postmortem examination results or other information received from the medical examiner only if relevant to transplantation or therapy.

(b) The medical examiner may conduct a medicolegal examination including physical examination of a donor or prospective donor and review of all medical records, laboratory test results, X-rays, other diagnostic results, and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the medical examiner or whose body would be under the medical examiner's jurisdiction upon death and that the medical examiner determines may be relevant to the investigation.

(c) A person that has any information requested by a medical examiner pursuant to subsection (b) of this section shall provide that information as expeditiously as possible to allow the medical examiner to conduct the medicolegal investigation within a period compatible with the preservation of body parts for the purpose of transplantation, therapy, research, or education.

(d) If an anatomical gift has been or might be made of a body part of a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is not required, or the medical examiner determines that a postmortem examination is required but that the recovery of the body part that is the subject of an anatomical gift will not interfere with the examination, the medical examiner and procurement organization shall cooperate in the timely removal of the body part from the decedent for the purpose of transplantation, therapy, research, or education.

(e) If an anatomical gift of a body part from the decedent under the jurisdiction of the medical examiner has been or might be made, but the medical examiner initially believes that the recovery of the body part could interfere with the postmortem investigation into the decedent's cause or manner of death, the collection of evidence, or the description, documentation, or interpretation of injuries on the body, the medical examiner shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the medical examiner may deny or allow the recovery.

(f) If the medical examiner or designee allows recovery of a body part under subsection (d) or (e) of this section, the procurement organization shall provide the medical examiner or designee with a record describing the condition of the body part signed by the physician or technician who removes the body part and any other information and observations that would assist in the postmortem examination."

SECTION 2. G.S. 20-43.2 reads as rewritten:

"**§ 20-43.2. Internet access to organ donation records by organ procurement organizations.**

(a) The Department of Transportation, Division of Motor Vehicles, shall establish and maintain a statewide, online Organ Donor Registry Internet ~~site.~~site (hereafter "Donor Registry"). The purpose of the ~~Organ Donor Internet site~~ Donor Registry is to enable federally designated organ procurement organizations and eye banks to have ~~timely access to~~access 24 hours per day, seven days per week to obtain relevant information on the Donor Registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift through a symbol on the donor's or prospective donor's drivers license, special identification card, or other manner. ~~the names of individuals who have stated to the Division the individual's intent to be an organ donor and have an organ donation symbol on the individual's drivers license or special identification card.~~ The data available on the ~~Organ Donor Internet site~~ Donor Registry shall be limited to the individual's first, middle, and last name, date of birth, address, sex, county of residence, and drivers license number. The Division of Motor Vehicles shall ensure that only federally designated organ procurement organizations and eye banks operating in this State have access to the ~~Organ Donor Internet site~~Donor Registry in read-only format. The Division of Motor Vehicles shall enable federally designated organ procurement organizations and eye banks operating in this State to have online access in read-only format to the ~~Organ Donor Internet site~~Donor Registry through a unique identifier and password issued to the organ procurement organization or eye bank by the Division of Motor Vehicles. ~~The read-only information from the Organ Donor Internet site will be used for the sole purpose of seeking consent from the individual's next of kin for organ, tissue, or eye donation.~~Employees of the Division who provide access to or disclosure of information in good-faith compliance with this section are not liable in damages for access to or disclosure of the information.

(b) When accessing and using information obtained from the ~~Organ Donor Internet site,~~Donor Registry, federally designated organ procurement organizations and

eye banks shall comply with the requirements of Part ~~3~~3A of Article 16 of Chapter 130A of the General Statutes.

(c) Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor, or person that made the anatomical gift for any purpose other than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift.

(d) This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the State. Any such registry must comply with subsections (b) and (c) of this section."

SECTION 3. The North Carolina Department of Transportation, Division of Motor Vehicles, in cooperation with the License to Give Trust Fund Commission, shall use available grant-in-aid funds from the State and federal governments and other sources to enhance online access such that donors and prospective donors may update, amend, or revoke information on the donor's or prospective donor's drivers license or donor card.

SECTION 4. This act modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001, et seq., but does not modify, limit, or supersede Section 101(a) of that act, 15 U.S.C. § 7001, or authorize electronic delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. § 7003(b).

SECTION 5.(a) G.S. 130A-410, 130A-411, 130A-412, 130A-412.1, and 130A-412.2 are recodified under Part 3A of Article 16 of Chapter 130A of the General Statutes, as enacted by this act, as G.S. 130A-412.26, 130A-412.27, 130A-412.28, 130A-412.29, and 130A-412.30 respectively.

SECTION 5.(b) Except as provided in subsection (a) of this section, Part 3 of Article 16 of Chapter 130A of the General Statutes is repealed.

SECTION 6. This act is effective when it becomes law.

HOUSE BILL 1372:
Organ & Tissue Donation/the Heart Prevails

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Judiciary II (Criminal)	**Date:**	June 19, 2007
Introduced by:	Reps. Folwell, Holliman, Clary, Wainwright	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to Second Edition H1372-CSRC-50		

SUMMARY: House bill 1372 would amend existing law to adopt the Revised Uniform Anatomical Gift Act (UAGA) as drafted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 2006. The most significant changes are as follows:

- *Individual choice to make an anatomical gift, as evidenced by the decision to place a 'heart' symbol on the person's drivers' license, will be sufficient to establish intent to donate without verifying choice with another person.*
- *Unless specified otherwise, priority will be given to use anatomical gifts for transplantation or therapy, if suitable, then for use for research or education.*
- *Rights and duties of 'procurement organizations' are set forth in statute – duty to conduct 'reasonable' search for evidence of anatomical gift, 'reasonable' examination to ensure medical suitability of body part, etc.*
- *Directs hospitals to enter into 'agreements or affiliations' with procurement organizations.*
- *Class H felony offenses for sale or purchase of body parts, or for falsification of donor records.*

The Proposed Committee Substitute differs from the 2nd Edition by limiting the scope of the anatomical gift that can be made solely by a symbol on a drivers license or identification card. An anatomical gift made in this manner would not include tissue or the donor's body.

CURRENT LAW: Part 3 of Article 16 of Chapter 130A of the General Statutes contains the Uniform Anatomical Gift Act (UAGA), based on the draft of the Act produced by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 1968 and enacted by the North Carolina General Assembly in 1969. See the Bill Analysis below for specific differences between existing law and the proposed legislation.

BILL ANALYSIS: The following is a section by section analysis of the proposed legislation:

Section 1 – Creates a new Part 3A in Article 16 of Chapter 130A

§ 130A-412.3 – Short title would be the "Revised Uniform Anatomical Gift Act.

§ 130A-412.4 – Expands the number of defined terms. Some new terms include:

"Anatomical Gift" – A donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

"Body part" – An organ, an eye, or tissue of a human being, but not the whole body. *Current law defines "part" as organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.*

"Disinterested witness" – A person other than the spouse, child, parent, sibling, grandchild, grandparent or guardian of the person who makes, amends, revokes or refuses to make a donation. It also includes a person who has exhibited special care and concern for the individual.

"Guardian" is a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual, but not a guardian ad litem.

"Know" means actual knowledge.

"Record" means information stored in a tangible medium or stored in an electronic medium and capable of being retrieved.

"Tissue" means a part of a human body other than an organ or an eye, but not blood unless donated for research or education.

§ 130A-412.5 – Applicability – the Act would be applicable to a gift, amendment, revocation or refusal regardless of when it is made. *This provision makes the Revised Act retroactive.*

§ 130A-412.6 – Who may make an anatomical gift prior to donor's death – The donor may make an anatomical gift if: the donor is an adult, the donor is an emancipated minor, or the donor is a minor who is 16 or 17 years old[1]. An agent of the donor may make an anatomical gift, unless the health care power of attorney prohibits the agent from making anatomical gifts. The parent of an unemancipated minor may make an anatomical gift, as may the guardian of the donor. *Existing law provides that, during the life of the donor, only a donor who is at least 18 years of age may make an anatomical donation[2]. The provision in the Revised Uniform Act related to donations by health care agents appears to conflict with existing law. G.S. 32A-19(b) provides that a health care agent may make anatomical donations if the principal expressing grants the agent that authority. The Revised Uniform Act takes the opposite approach by providing that the agent has that authority unless the principal expressly removes it. It is not clear which provision would control.*

§ 130A-412.7 – Manner of making anatomical gift before donor's death

1. Donor may make a gift of: (a) organs or eyes by including a symbol on a drivers license or identification care, (b) of any body part or the donor's body by will, or (c) during a terminal illness or injury by any form of communication to at least 2 adults, one of which must be a disinterested witness.

2. A donor or other authorized person may make a donation by: (a) a donor card, (b) a signed record, or (c) being included on a donor registry.

Current law provides a donation may be made by will. The donation may also be made by a document other than a will, provided the document is signed by the donor and two witnesses.

§ 130A-412.8 – Amending or revoking an anatomical gift.

An anatomical gift may be amended or revoked by the donor or any person authorized to make a donation. The revocation can be made by a record signed by the donor or a person authorized to make a donation, by a later-executed document of gift, by the destruction or cancellation of the document of gift, or a portion of a document of gift. A donor may amend or revoke a donation that is not made by will by any form of communication during a terminal illness or injury, if the communication is made to at least 2 adults, 1 of whom is a disinterested witness. *Current law allows an amendment or revocation by: (a) delivery of a signed statement to the donee, (b) an oral statement made in the presence of 2*

[1] However, a parent of an unemancipated minor could revoke or amend either an anatomical donation or a refusal made by the minor.
[2] G.S. 130A-404(a)

ersons and communicated to the donee, (c) a statement during a terminal illness or injury made to an attending physician and communicated to the donee; or a signed document made known to the donee. If the donation has not been delivered to the donee, the donation may be amended or revoked by destruction, cancellation or mutilation of the document and all executed copies.

§ 130A-412.9 – Refusal to make anatomical gift; effect of refusal

A refusal is a record that expressly states an intent to bar other persons from making an anatomical gift. It can be made by a signed record by the donor or a person acting at the direction of the donor, by the donor's will, or any other form of communication to at least 2 adults, one of whom is a disinterested witness and made during a terminal illness or injury. A person may amend or revoke a refusal by any methods of making a refusal, by making an anatomical gift, or by destroying or cancelling the record evidencing the refusal. An unrevoked refusal bars other individuals from making an anatomical gift. *Current law allows the revocation of an anatomical gift in a will by any method that is allowed to revoke or amend a will.*

§ 130A-412.10 – Preclusive effect of an anatomical gift, amendment or revocation.

A person other than the donor who is authorized to make an anatomical donation may not make, amend or revoke a donation if the donor made or amended a donation during the donor's lifetime. A donor's revocation is not considered a refusal and does not preclude another person authorized to make a donation from doing so. If an authorized person (other than the donor) makes an anatomical gift, the gift may not be amended or revoked by another person authorized to make an anatomical gift. If one of those individuals revokes the gift, another person authorized to make the gift may do so. An anatomical gift of a particular body part does not preclude gifts of other body parts at a later time by the donor or authorized person. An anatomical donation for a particular purpose is not a limitation on the making of other donations for other purposes.

§ 130A-412.11 – Who may make an anatomical gift of the decedent's body or body parts. – Any of the following persons, in descending order, have the authority to make an anatomical gift of the decedent's body or body parts after the decedent has died: (1) an agent who could have made a donation during the decedent's life, (2) the decedent's spouse, (3) adult children of the decedent, (4) parents of the decedent, (5) adult siblings of the decedent, (6) adult grandchildren of the decedent, (7) grandparents of the decedent, (8) an adult who has exhibited special care and concern for the decedent. (9) persons acting as guardian at the time of death, and (10) other persons with authority to dispose of decedent's body. *Current law gives this authority to (1) the health care agent with authority to make anatomical gifts, (2) the spouse, (3) an adult child, (4) either parent, (5) an adult sibling, (6) the donor's guardian, (7) any other person authorized to dispose of the body.*

§ 130A-412.12 – Manner of making, amending, or revoking anatomical gift of decedent's body or body part. – An anatomical gift made after the donor's death may be made by a signed document or by an oral communication that is reduced to a record. This donation may be amended or revoked by a signed document. A revocation is effective only if the party that is going to harvest the body part has actual knowledge of the revocation or amendment prior to making an incision or invasive procedure.

§ 130A-412.13 – Persons who may receive anatomical gift; purpose of gift. – if the purpose of the gift is research or education, the recipient must be a hospital, medical school or dental school, college or university, or organ procurement organization. An individual may be designated to receive the gift if that individual will also be the recipient of the body part. An eye or tissue bank may also receive an anatomical gift. A gift made by a symbol on a drivers license may only be used for transplantation or therapy. If the body part is an eye, it must go to the appropriate eye bank. If the body part is an organ, it

must go to the appropriate organ procurement organization. A person may not accept an anatomical gift if the person knows the gift was not made by the authorized methods. *Current law allows the following persons to receive an anatomical gift: a hospital, surgeon or physician for education or research or transplantation or therapy; a medical or dental school to advance education, research, or therapy; a bank or storage facility for medical or dental research; a specified individual for therapy or transplantation; the Commission for anatomy for distribution for studying anatomy.*

§ 130A-412.14 – Search and notification. A hospital or law enforcement office who reasonably believes an individual is dead or near death must make a reasonable search of that individual to locate either a document of gift or a refusal. There is no criminal liability for failing to make this search.

§ 130A-412.15 – Delivery of document of gift not required. An anatomical gift does not have to be delivered during the donor's lifetime in order to be effective.

§ 130A-412.16 – Rights and duties f procurement organizations. If a person at or near death is referred to a procurement organization, that organization must make a reasonable search of DMV records and other donor registries in the area to determine whether the donor has made an anatomical gift. The organization may make a reasonable examination to determine medical suitability of the body part for transplantation, therapy, research, or education. Measures necessary to ensure medical suitability may not be withdrawn during this period of examination unless the donor has expressed a contrary intent. The examination for medical suitability includes an examination of all medical and dental records of the donor. Neither the physician who attends the decedent at death who determines the time of death may participate in the harvesting procedures.

§ 130A-412.17 – Coordination of procurement and use – Each hospital in the State must enter into agreements or affiliations with procurement organizations for the coordination of procurement.

§ 130A-412.18. Sale or purchase of body parts prohibited – A person who knowingly sells or purchases a body part for transplantation or therapy is guilty of a Class H felony if the removal of the body part is intended to occur after the individual's death.

§ 130A-412.19. – Other prohibited acts – It is a Class H felony to intentionally falsify, conceal or destroy a document of gift, an amendment, revocation or refusal if the act is made to obtain financial gain.

§ 130A-412.20. – Immunity. – A person who acts with due care under this Part or attempts a good faith effort to do so is not liable in any civil or criminal action. A third party may rely upon representations made by individuals regarding their relationship to the donor unless the third party has actual knowledge the information is false.

§ 130A-412.21 – Choice of law; presumption of validity. – The document of gift is valid if executed in accordance with the laws of North Carolina, the laws of the state or jurisdiction where the document was executed, or the laws of any location the donor had some contact with at the time of document was executed. The laws of North Carolina shall apply to the interpretation of the document.

§ 130A-412.22. – Donor registry. – The Organ Donor Registry Internet site created under G.S. 20-43.2 shall be the State' donor registry for anatomical gifts made under this act.

§ 130A-412.23 – Effect of anatomical gift on advanced directive – Measures to ensure medical suitability shall not be withheld or withdrawn from a prospective donor unless an advanced directive expressly provides to the contrary.

130A-412.24 – Cooperation between medical examiner and procurement organization. – Medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts.

§ 130A-412.25 – Facilitation of anatomical gift from decedent whose body is under jurisdiction of medical examiner. – Outlines the procedures for recover of a body part that is the subject of an anatomical gift when the body of the decedent is under the control of a medical examiner.

Section 2 amends G.S. 20-43.2 to require that the Organ Donor Registry Internet site (Donor Registry) be accessible 24 hours a day, seven days a week. Personally identifiable information about a donor or prospective donor would not be used or disclosed without the express permission of the donor for any purpose other than to determine whether the donor made, amended or revoked the donation.

Section 3 directs DMV to work with the License to Give Trust Fund Commission to use grant-in-aid funds and other sources to enhance online access to the Donor Registry.

Section 4 provides that the act modifies, limits and supersedes the Electronic Signatures in Global and National Commerce Act, but not federal law regarding electronic delivery of notices.

Section 5 recodifies portions of existing Part 3 of Article 16 of Chapter 130A and repeals those portions that are the existing Uniform Anatomical Gift Act.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The 2006 revision of the UAGA has been enacted in 14 states, and drafts of the revised UAGA are under consideration in 16 states. NCCUSL promulgated the first version of the UAGA in 1968 and has offered two major revisions to the Act since then, first in 1987 and then 2006. Every state has adopted at least one of the versions of the UAGA, but variation among versions enacted has led to a lack of nationwide uniformity of state laws governing organ, tissue and eye donation.

Ben Popkin, counsel to House Health Committee?, substantially contributed to this summary.

H1372e2-SMRC-CSRC-50

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 1372

Committee Substitute Favorable 5/2/07

Short Title: Organ & Tissue Donation/the Heart Prevails. (Public)

Sponsors:

Referred to:

April 10, 2007

A BILL TO BE ENTITLED

AN ACT TO ENACT THE REVISED UNIFORM ANATOMICAL GIFT ACT; TO PROVIDE THAT THE DECISION TO HAVE THE HEART SYMBOL ON ONE'S DRIVERS LICENSE IS LEGALLY SUFFICIENT CONSENT TO ORGAN AND TISSUE DONATION UNLESS REVOKED BY THE DONOR; TO IMPROVE DONOR OR PROSPECTIVE DONOR ONLINE ACCESS TO INDICATE OR REVOKE ORGAN AND TISSUE DONATION; AND TO MAKE CONFORMING CHANGES TO OTHER AFFECTED GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 16 of Chapter 130A of the General Statutes is amended by adding the following new Part to read:

"Part 3A. Revised Uniform Anatomical Gift Act.

"**§ 130A-412.3. Short title.**

This Part may be cited as the Revised Uniform Anatomical Gift Act.

"**§ 130A-412.4. Definitions.**

The following definitions apply in this Part.

(1) "Adult" means an individual who is at least 18 years of age.

(2) "Agent" means an individual:

a. Authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

b. Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

(4) "Body part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

(5) "Decedent" means a deceased individual whose body or body part is or may be the source of an anatomical gift. The term includes a stillborn

infant and, subject to restrictions imposed by law other than this Article, a fetus.

(6) "Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to whom an anatomical gift could pass under G.S. 130A-412.13.

(7) "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a drivers license, identification card, or donor registry.

(8) "Donor" means an individual whose body or body part is the subject of an anatomical gift.

(9) "Donor registry" means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.

(10) "Drivers license" means a license or permit issued by the North Carolina Department of Transportation, Division of Motor Vehicles, to operate a vehicle, whether or not conditions are attached to the license or permit.

(11) "Eye bank" means an entity that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.

(12) "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.

(13) "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

(14) "Identification card" means an identification card issued by the North Carolina Department of Transportation, Division of Motor Vehicles.

(15) "Know" means to have actual knowledge.

(16) "Minor" means an individual who is under 18 years of age.

(17) "Organ procurement organization" means a person designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization.

(18) "Parent" means a parent whose parental rights have not been terminated.

(19) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(20) "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

(21) "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

(22) "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a body part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

(23) "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

(24) "Recipient" means an individual into whose body a decedent's body part has been or is intended to be transplanted.

(25) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(26) "Refusal" means a record created under G.S. 130A-412.9 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or body part.

(27) "Sign" means, with the present intent to authenticate or adopt a record:

a. To execute or adopt a tangible symbol; or

b. To attach to or logically associate with the record an electronic symbol, sound, or process.

(28) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(29) "Technician" means an individual determined to be qualified to remove or process body parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an enucleator.

(30) "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

(31) "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

(32) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

"**§ 130A-412.5. Applicability.**

This act applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

"**§ 130A-412.6. Who may make an anatomical gift before donor's death.**

Subject to G.S. 130A-412.10, an anatomical gift of a donor's body or body part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in G.S. 130A-412.7 by:

(1) The donor, if the donor is an adult or if the donor is a minor and is:

a. Emancipated; or

b. Authorized under State law to apply for a drivers license because the donor is at least 16 years of age;

(2) An agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(3) A parent of the donor, if the donor is an unemancipated minor; or

(4) The donor's guardian.

"**§ 130A-412.7. Manner of making anatomical gift before donor's death.**

(a) A donor may make an anatomical gift:

(1) By authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's drivers license or identification card;

(2) In a will;

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness; or

(4) As provided in subsection (b) of this section.

(b) A donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) Revocation, suspension, expiration, or cancellation of a drivers license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(d) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

"**§ 130A-412.8. Amending or revoking anatomical gift before donor's death.**

(a) Subject to G.S. 130A-412.10, a donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may amend or revoke an anatomical gift by:

(1) A record signed by:

a. The donor;

b. The other person; or

c. Subject to subsection (b) of this section, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(2) A later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

(b) A record signed pursuant to sub-subdivision c. of subdivision (1) of subsection (a) of this section must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) Subject to G.S. 130A-412.10, a donor or other person authorized to make an anatomical gift under G.S. 130A-412.6 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(d) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(e) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection (a) of this section.

"**§ 130A-412.9. Refusal to make anatomical gift; effect of refusal.**

(a) An individual may refuse to make an anatomical gift of the individual's body or body part by:

(1) A record signed by:

a. The individual; or

b. Subject to subsection (b) of this section, another individual acting at the direction of the individual if the individual is physically unable to sign;

(2) The individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(3) Any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(b) A record signed pursuant to sub-subdivision b. of subdivision (1) of subsection (a) of this section must:

(1) Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(2) State that it has been signed and witnessed as provided in subdivision (1) of this subsection.

(c) An individual who has made a refusal may amend or revoke the refusal:

(1) In the manner provided in subsection (a) of this section for making a refusal;
(2) By subsequently making an anatomical gift pursuant to G.S. 130A-412.7 that is inconsistent with the refusal; or
(3) By destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(d) Except as otherwise provided in G.S. 130A-412.10(h), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or body part bars all other persons from making an anatomical gift of the individual's body or body part.

"§ 130A-412.10. Preclusive effect of an anatomical gift, amendment, or revocation.

(a) Except as otherwise provided in subsection (g) of this section and subject to subsection (f) of this section, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or body part if the donor made an anatomical gift of the donor's body or body part under G.S. 130A-412.7 or an amendment to an anatomical gift of the donor's body or body part under G.S. 130A-412.8.

(b) A donor's revocation of an anatomical gift of the donor's body or body part under G.S. 130A-412.8 is not a refusal and does not bar another person specified in G.S. 130A-412.6 or G.S. 130A-412.11 from making an anatomical gift of the donor's body or body part under G.S. 130A-412.7 or G.S. 130A-412.12.

(c) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or body part under G.S. 130A-412.7 or an amendment to an anatomical gift of the donor's body or body part under G.S. 130A-412.8, another person may not make, amend, or revoke the gift of the donor's body or body part under G.S. 130A-412.12.

(d) A revocation of an anatomical gift of a donor's body or body part under G.S. 130A-412.8 by a person other than the donor does not bar another person from making an anatomical gift of the body or body part under G.S. 130A-412.7 or G.S. 130A-412.12.

(e) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under G.S. 130A-412.6, an anatomical gift of a body part is neither a refusal to give another body part nor a limitation on the making of an anatomical gift of another body part at a later time by the donor or another person.

(f) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under G.S. 130A-412.6, an anatomical gift of a body part for one or more of the purposes set forth in G.S. 130A-412.6 is not a limitation on the making of an anatomical gift of the body part for any of the other purposes by the donor or any other person under G.S. 130A-412.7 or G.S. 130A-412.12.

(g) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or body part.

(h) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

"**§ 130A-412.11. Who may make an anatomical gift of decedent's body or body part.**

(a) Subject to subsections (b) and (c) of this section, and unless barred by G.S. 130A-412.9 or G.S. 130A-412.10, an anatomical gift of a decedent's body or body part for purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(1) An agent of the decedent at the time of death who could have made an anatomical gift under G.S. 130A-412.6(2) immediately before the decedent's death;
(2) The spouse of the decedent;
(3) Adult children of the decedent;
(4) Parents of the decedent;
(5) Adult siblings of the decedent;
(6) Adult grandchildren of the decedent;
(7) Grandparents of the decedent;
(8) An adult who exhibited special care and concern for the decedent;
(9) The persons who were acting as the guardians of the person of the decedent at the time of death; and
(10) Any other person having the authority to dispose of the decedent's body.

(b) If there is more than one member of a class listed in subsection (a)(1), (3), (4), (5), (6), (7), or (9) of this section entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under G.S. 130A-412.13 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(c) A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection (a) of this section is reasonably available to make or to object to the making of an anatomical gift.

"**§ 130A-412.12. Manner of making, amending, or revoking anatomical gift of decedent's body or body part.**

(a) A person authorized to make an anatomical gift under G.S. 130A-412.11 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(b) Subject to subsection (c) of this section, an anatomical gift by a person authorized under G.S. 130A-412.11 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under G.S. 130A-412.11 may be:

(1) Amended only if a majority of the reasonably available members agrees to the amending of the gift; or

(2) Revoked only if a majority of the reasonably available members agrees to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(c) A revocation under subsection (b) of this section is effective only if, before an incision has been made to remove a body part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

"**§ 130A-412.13. Persons that may receive anatomical gift; purpose of anatomical gift.**

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) A hospital; accredited medical school, dental school, college, or university; organ procurement organization; or other appropriate person, for research or education;

(2) Subject to subsection (b) of this section, an individual designated by the person making the anatomical gift if the individual is the recipient of the body part;

(3) An eye bank or tissue bank.

(b) If an anatomical gift to an individual under subsection (a)(2) of this section cannot be transplanted into the individual, the body part passes in accordance with subsection (g) of this section in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific body parts or of all body parts is made in a document of gift that does not name a person described in subsection (a) of this section but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) If the body part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

(2) If the body part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

(3) If the body part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(4) If the body part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of subsection (c) of this section, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific body parts is made in a document of gift that does not name a person described in subsection (a) of this section and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g) of this section.

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g) of this section.

(g) For purposes of subsections (b), (e), and (f) of this section the following rules apply:

(1) If the body part is an eye, the gift passes to the appropriate eye bank.

(2) If the body part is tissue, the gift passes to the appropriate tissue bank.

(3) If the body part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under subsection (a)(2) of this section, passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to subsections (a) through (h) of this section or the decedent's body or body part is not used for transplantation, therapy, research, or education, then custody of the body or body part passes to the person under obligation to dispose of the body or body part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under G.S. 130A-412.7 or G.S. 130A-412.12 or if the person knows that the decedent made a refusal under G.S. 130A-412.9 that was not revoked. For purposes of the subsection, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in subdivision (a)(2) of this section, nothing in this act affects the allocation of organs for transplantation or therapy.

"**§ 130A-412.14. Search and notification.**

(a) The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) A law enforcement officer, firefighter, paramedic, or other emergency rescuer finding the individual; and

(2) If no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

(b) If a document of gift or a refusal to make an anatomical gift is located by the search required by subdivision (a)(1) of this section and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

(c) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

"§ 130A-412.15. Delivery of document of gift not required; right to examine.

(a) A document of gift need not be delivered during the donor's lifetime to be effective.

(b) Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under G.S. 130A-412.13.

"§ 130A-412.16. Rights and duties of procurement organization and others.

(a) When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the North Carolina Department of Transportation, Division of Motor Vehicles, and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

(b) A procurement organization must be allowed reasonable access to information in the records of the North Carolina Department of Transportation, Division of Motor Vehicles, to ascertain whether an individual at or near death is a donor.

(c) When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a body part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the body part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(d) Unless prohibited by law other than this Part, at any time after a donor's death, the person to which a body part passes under G.S. 130A-412.13 may conduct any reasonable examination necessary to ensure the medical suitability of the body or body part for its intended purpose.

(e) Unless otherwise prohibited by law, an examination under subsection (c) or (d) of this section may include an examination of all medical and dental records of the donor or prospective donor.

(f) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(g) Upon referral by a hospital under subsection (a) of this section, a procurement organization shall make a reasonable search for any person listed in G.S. 130A-412.11 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

(h) Subject to G.S. 130A-412.13(i) and G.S. 130A-412.25, the rights of the person to which a body part passes under G.S. 130A-412.13 are superior to the rights of all others with respect to the body part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and this Part, a person that accepts an anatomical gift of an entire body may allow embalming, burial, or cremation and use of remains in a funeral service. If the gift is of a body part, the person to which the body part passes under G.S. 130A-412.13, upon the death of the donor and before embalming, burial, or cremation, shall cause the body part to be removed without unnecessary mutilation.

(i) Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

(j) A physician or technician may remove a donated body part from the body of a donor that the physician or technician is qualified to remove.

"**§ 130A-412.17. Coordination of procurement and use.**

Each hospital in this State shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

"**§ 130A-412.18. Sale or purchase of body parts prohibited.**

(a) Except as otherwise provided in subsection (b) of this section, a person, that for valuable consideration, knowingly purchases or sells a body part for transplantation or therapy if removal of a body part from an individual is intended to occur after the individual's death commits a Class H felony and upon conviction is subject to a fine not exceeding fifty thousand dollars ($50,000) or imprisonment not exceeding five years, or both.

(b) A person may charge a reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a body part.

"**§ 130A-412.19. Other prohibited acts.**

A person that, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces, or obliterates a document of gift, an amendment or revocation of a document of gift, or a refusal commits a Class H felony and upon conviction is subject to a fine not exceeding fifty thousand dollars ($50,000) or imprisonment not exceeding five years, or both.

"**§ 130A-412.20. Immunity.**

(a) A person that acts with due care in accordance with this Part or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

(b) Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

(c) In determining whether an anatomical gift has been made, amended, or revoked under this Part, a person may rely upon representations of an individual listed in subdivisions (2) through (8) of G.S. 130A-412.11(a) relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

"§ 130A-412.21. Law governing validity; choice of law as to execution of document of gift; presumption of validity.

(a) A document of gift is valid if executed in accordance with:

(1) This Part;

(2) The laws of the state or country where it was executed; or

(3) The laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

(b) If a document of gift is valid under this section, the law of this State governs the interpretation of the document of gift.

(c) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

"§ 130A-412.22. Donor registry.

The online Organ Donor Registry Internet site established pursuant to G.S. 20-43.2 shall be the State donor registry for anatomical gifts made pursuant to this Part. Requirements for maintenance and use of the State donor registry shall be as provided under G.S. 20-43.2.

"§ 130A-412.23. Effect of anatomical gift on health care power of attorney.

(a) The following definitions apply in this Part:

(1) "Advanced health care directive." – A health care power of attorney under G.S. 32A-16 or a record signed or authorized by a prospective donor containing the prospective donor's direction concerning a health care decision for the prospective donor.

(2) "Declaration." – A declaration of a desire for a natural death as provided under Article 23 of Chapter 90 of the General Statutes.

(3) "Health care decision." – Any decision made regarding the health care of the prospective donor.

(b) If a prospective donor has a declaration or advanced health care directive, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor unless the declaration expressly provides to the contrary.

"§ 130A-412.24. Cooperation between a medical examiner and the procurement organization.

(a) The medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

(b) If a medical examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is going to be performed, unless the medical examiner denies recovery in accordance with G.S. 130A-412.25, the medical examiner or designee shall conduct a postmortem examination of the body or the body part in a manner and within a period compatible with its preservation for the purposes of the gift.

(c) A body part may not be removed from the body of a decedent under the jurisdiction of a medical examiner for transplantation, therapy, research, or education unless the body part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This subsection does not preclude a medical examiner from performing the medicolegal investigation upon the body or body parts of a decedent under the jurisdiction of the medical examiner.

(d) As used in this section and G.S. 130A-412.25, 'medical examiner' includes the Chief Medical Examiner, a county medical examiner, or a designee of either.

"**§ 130A-412.25. Facilitation of anatomical gift from decedent whose body is under the jurisdiction of a medical examiner.**

(a) Upon request of a procurement organization, a medical examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is or will come under the jurisdiction of the medical examiner. If the decedent's body or body part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the postmortem examination results or other information received from the medical examiner only if relevant to transplantation or therapy.

(b) The medical examiner may conduct a medicolegal examination including physical examination of a donor or prospective donor and review of all medical records, laboratory test results, X-rays, other diagnostic results, and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the medical examiner or whose body would be under the medical examiner's jurisdiction upon death and that the medical examiner determines may be relevant to the investigation.

(c) A person that has any information requested by a medical examiner pursuant to subsection (b) of this section shall provide that information as expeditiously as possible to allow the medical examiner to conduct the medicolegal investigation within a period compatible with the preservation of body parts for the purpose of transplantation, therapy, research, or education.

(d) If an anatomical gift has been or might be made of a body part of a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is not required, or the medical examiner determines that a postmortem examination is required but that the recovery of the body part that is the subject of an anatomical gift will not interfere with the examination, the medical examiner and procurement organization shall cooperate in the timely removal of the body part from the decedent for the purpose of transplantation, therapy, research, or education.

(e) If an anatomical gift of a body part from the decedent under the jurisdiction of the medical examiner has been or might be made, but the medical examiner initially believes that the recovery of the body part could interfere with the postmortem investigation into the decedent's cause or manner of death, the collection of evidence, or the description, documentation, or interpretation of injuries on the body, the medical

examiner shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the medical examiner may deny or allow the recovery.

(f) If the medical examiner or designee allows recovery of a body part under subsection (d) or (e) of this section, the procurement organization shall provide the medical examiner or designee with a record describing the condition of the body part signed by the physician or technician who removes the body part and any other information and observations that would assist in the postmortem examination."

SECTION 2. G.S. 20-43.2 reads as rewritten:

"§ 20-43.2. Internet access to organ donation records by organ procurement organizations.

(a) The Department of Transportation, Division of Motor Vehicles, shall establish and maintain a statewide, online Organ Donor Registry Internet ~~site.~~site (hereafter "Donor Registry"). The purpose of the ~~Organ Donor Internet site~~ Donor Registry is to enable federally designated organ procurement organizations and eye banks to have ~~timely access to~~access 24 hours per day, seven days per week to obtain relevant information on the Donor Registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift through a symbol on the donor's or prospective donor's drivers license, special identification card, or other manner. ~~the names of individuals who have stated to the Division the individual's intent to be an organ donor and have an organ donation symbol on the individual's drivers license or special identification card.~~ The data available on the ~~Organ Donor Internet site~~ Donor Registry shall be limited to the individual's first, middle, and last name, date of birth, address, sex, county of residence, and drivers license number. The Division of Motor Vehicles shall ensure that only federally designated organ procurement organizations and eye banks operating in this State have access to the ~~Organ Donor Internet site~~Donor Registry in read-only format. The Division of Motor Vehicles shall enable federally designated organ procurement organizations and eye banks operating in this State to have online access in read-only format to the ~~Organ Donor Internet site~~Donor Registry through a unique identifier and password issued to the organ procurement organization or eye bank by the Division of Motor Vehicles. ~~The read-only information from the Organ Donor Internet site will be used for the sole purpose of seeking consent from the individual's next of kin for organ, tissue, or eye donation.~~Employees of the Division who provide access to or disclosure of information in good-faith compliance with this section are not liable in damages for access to or disclosure of the information.

(b) When accessing and using information obtained from the ~~Organ Donor Internet site,~~Donor Registry, federally designated organ procurement organizations and eye banks shall comply with the requirements of Part ~~3~~3A of Article 16 of Chapter 130A of the General Statutes.

(c) Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor, or person that made the anatomical gift for any purpose other

than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift.

(d) This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the State. Any such registry must comply with subsections (b) and (c) of this section."

SECTION 3. The North Carolina Department of Transportation, Division of Motor Vehicles, in cooperation with the License to Give Trust Fund Commission, shall use available grant-in-aid funds from the State and federal governments and other sources to enhance online access such that donors and prospective donors may update, amend, or revoke information on the donor's or prospective donor's drivers license or donor card.

SECTION 4. This act modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001, et seq., but does not modify, limit, or supersede Section 101(a) of that act, 15 U.S.C. § 7001, or authorize electronic delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. § 7003(b).

SECTION 5.(a) G.S. 130A-410, 130A-411, 130A-412, 130A-412.1, and 130A-412.2 are recodified under Part 3A of Article 16 of Chapter 130A of the General Statutes, as enacted by this act, as G.S. 130A-412.26, 130A-412.27, 130A-412.28, 130A-412.29, and 130A-412.30 respectively.

SECTION 5.(b) Except as provided in subsection (a) of this section, Part 3 of Article 16 of Chapter 130A of the General Statutes is repealed.

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1488

Committee Substitute Favorable 5/7/07

Committee Substitute #2 Favorable 6/5/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1488-PCS80455-RD-34

Short Title: Amend Psychology Practice Act. (Public)

Sponsors:

Referred to:

April 17, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE PSYCHOLOGY PRACTICE ACT TO CLARIFY REQUIREMENTS FOR PERMANENT LICENSURE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.4(e) reads as rewritten:

"(e) ~~Nothing~~ Subject to subsection (g) of this section, nothing in this Article shall be construed to prevent a qualified ~~members~~ member of other professional groups licensed or certified under the laws of this State from rendering services within the scope of practice, as defined in the statutes regulating those professional practices, provided ~~they do~~ the person does not hold ~~themselves~~ himself or herself out to the public by any title or description stating or implying that ~~they are psychologists~~the person is a psychologist or ~~are~~ licensed, certified, or registered to practice psychology."

SECTION 2. G.S. 90-270.4(g) reads as rewritten:

"(g) Except as ~~otherwise provided in this Article,~~ provided in subsection (c) of this section, if a person who is otherwise exempt from the provisions of this Article and not required to be licensed under this Article is or becomes licensed under this Article, he or she shall ~~be required to~~ comply with all ~~conditions, requirements, and obligations imposed by~~ Board rules ~~or by statute upon~~ and statutes applicable to all other psychologists licensed under this ~~Article.~~Article. These requirements apply regardless of whether the person holds himself or herself out to the public by any title or description stating or implying that the person is a psychologist, a licensed psychological associate, or licensed to practice psychology."

SECTION 3. G.S. 90-270.6 reads as rewritten:

"**§ 90-270.6. Psychology Board; appointment; term of office; composition.**

For the purpose of carrying out the provisions of this Article, there is created a North Carolina Psychology Board, which shall consist of seven members appointed by the

Governor. At all times three members shall be licensed psychologists, two members shall be licensed psychological associates, and two members shall be members of the public who are not licensed under this Article. ~~Each member of the Board must reside in a different congressional district at the time of the appointment. Due~~ The Governor shall give due consideration ~~shall also be given~~ to the adequate representation of the various fields and areas of practice of ~~psychology.~~psychology and to adequate representation from various geographic regions in the State. Terms of office shall be three years. All terms of service on the Board expire June 30 in appropriate years. As the term of a psychologist member expires, or as a vacancy of a psychologist member occurs for any other reason, the North Carolina Psychological Association, or its successor, shall, having sought the advice of the chairs of the graduate departments of psychology in the State, for each vacancy, submit to the Governor a list of the names of three eligible persons. From this list the Governor shall make the appointment for a full term, or for the remainder of the unexpired term, if any. Each Board member shall serve until his or her successor has been appointed. As the term of a member expires, or if one should become vacant for any reason, the Governor shall appoint a new member within 60 days of the vacancy's occurring. No member, either public or licensed under this Article, shall serve more than three complete consecutive terms."

SECTION 4. G.S. 90-270.13(a) reads as rewritten:

"(a) Upon application and payment of the ~~requisite~~ required fee, the Board shall grant permanent licensure at the appropriate level to any person who, at the time of ~~application, is~~ application meets all of the following requirements:

(1) Is licensed or certified as a psychologist by a similar psychology licensing board in another ~~jurisdiction, whose~~ jurisdiction.

(2) The license or certification is in good ~~standing, who is~~ standing.

(3) Is a graduate of an institution of higher ~~education, who passes any~~ education.

(4) Who passes an examination prescribed by the ~~Board, and who meets~~ Board.

(5) Meets the definition of a senior psychologist as that term is defined by the rules of the Board."

SECTION 5. G.S. 90-270.13 is amended by adding a new subsection to read:

"(a1) Upon application and payment of the required fee, the Board shall grant permanent licensure at the appropriate level to any person who, at the time of application, meets all of the following requirements:

(1) Is licensed or certified as a psychologist by a similar psychology licensing board in another jurisdiction.

(2) The license or certification is in good standing.

(3) Possesses a doctoral degree in psychology from an institution of higher education.

(4) Passes an examination prescribed by the Board.

(5) Has no unresolved complaints in any jurisdiction at the time of application in this State.

(6) Holds a current credential for psychology licensure mobility, as defined in rules adopted by the Board."

SECTION 6. G.S. 90-270.13(f) reads as rewritten:

"(f) The Board may deny licensure to any person otherwise eligible for permanent licensure under this ~~subsection~~ section upon documentation of ~~illegal, immoral, dishonorable, unprofessional, or unethical~~ conduct ~~as~~ specified in G.S. 90-270.15."

SECTION 7. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1488

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

H1488-ARD-11 [v.1]

Date _____,2007

Comm. Sub. [NO]
Amends Title [NO]
Third Edition

Senator _____

moves to amend the bill on page 3, line 1, by deleting the phrase "G.S. 270.13(f)" and substituting the phrase "G.S. 90-270.13(f)".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 1488:
Amend Psychology Practice Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 19, 2007
Introduced by:	Rep. Goodwin	**Summary by:**	Ben Popkin
Version:	Third Edition		Committee Counsel

SUMMARY: House Bill 1488 would amend the Psychology Practice Act to clarify that a person who is dually licensed and is practicing psychology, but is not holding himself or herself out to the public as a psychologist, must comply with the requirements of the Article. It would remove the requirement that members of the Psychology Board must reside in different congressional districts. Finally, it would allow the Board to grant permanent licensure to persons who are licensed in other jurisdictions and hold a current credential for psychology licensure mobility.

CURRENT LAW:

G.S. 90-270.4(e) provides that nothing in the Psychology Practice Act requires a person who is a qualified member of another professional group from rendering services within the scope of that practice as long as the person does not hold himself or herself out as a psychologist. G.S. 90-270.4(g) provides that if that person is also licensed as a psychologist (holds dual licensure); the person does have to comply with the Psychology Practice Act. The North Carolina Court of Appeals recently held that the North Carolina Psychology Board did not have the authority to discipline a licensed psychological association who was also a licensed counselor for failure to comply with supervision requirements under the Practice act because the individual was not holding himself out at a psychologist.[1]

G.S. 90-270.6 requires that each member of the seven member North Carolina Psychology Board (Board) must reside in a different congressional district at the time the person is appointed to serve on the Board.

G.S. 90-270.13 allows the Board to grant licensure to psychologists licensed or certified in other jurisdictions if the applicant meets certain requirements. These requirements include: payment of the required application fee, licensure in good standing with a similar psychology licensing board, graduation from an institution of higher education, successful passage of the Board's examination, and meets the definition of a senior psychologist as defined by Board rules.

BILL ANALYSIS:

Sections 1 and 2 would amend G.S. 90-270.4(e) and (g) to clarify that a person who holds dual licensure must comply with the Psychology Practice Act requirements regardless of whether the person is holding himself or herself out as a psychologist.

Section 3 would remove from G.S. 90-270.6 the requirement that all members of the Board must reside in different congressional districts at the time of their appointment. It would require the Governor to take into consideration adequate representation from various geographic regions of the State.

Section 4 would make grammatical and stylistic changes to G.S. 90-270.13(a).

[1] 619 SE 2d 862 (2005)

Section 5 would create a new subsection (a1) to G.S. 90-270.13 that would allow the Board to grant permanent licensure to an individual who meets all of the following criteria:

- The individual is licensed or certified as a psychologist by a similar psychology licensing board in another jurisdiction,
- The individual's license or certification is in good standing,
- The individual passes the Board's exam,
- The individual holds a PhD in Psychology,
- The individual has no outstanding unresolved complaints in any jurisdiction (i.e., in other states), and
- The individual holds a current credential for psychology licensure mobility.

Section 6 clarifies language in G.S. 90-270.13(f) regarding the Board's discretion to deny licensure to a person licensed as a psychologist in another state due to conduct prohibited under G.S. 90-270.15.

EFFECTIVE DATE: The act is effective when it becomes law.

**Modified from a summary originally prepared by Kory Goldsmith*

H1488e3-SMRD

HOUSE BILL 1488

Committee Substitute Favorable 5/7/07
Committee Substitute #2 Favorable 6/5/07

Short Title: Amend Psychology Practice Act. (Public)

Sponsors:

Referred to:

April 17, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE PSYCHOLOGY PRACTICE ACT TO CLARIFY REQUIREMENTS FOR PERMANENT LICENSURE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.4(e) reads as rewritten:

"(e) ~~Nothing~~ Subject to subsection (g) of this section, nothing in this Article shall be construed to prevent a qualified ~~members~~ member of other professional groups licensed or certified under the laws of this State from rendering services within the scope of practice, as defined in the statutes regulating those professional practices, provided ~~they do~~ the person does not hold ~~themselves~~ himself or herself out to the public by any title or description stating or implying that ~~they are psychologists~~the person is a psychologist or ~~are~~ licensed, certified, or registered to practice psychology."

SECTION 2. G.S. 90-270.4(g) reads as rewritten:

"(g) Except as ~~otherwise provided in this Article,~~ provided in subsection (c) of this section, if a person who is otherwise exempt from the provisions of this Article and not required to be licensed under this Article is or becomes licensed under this Article, he or she shall ~~be required to~~ comply with all ~~conditions, requirements, and obligations imposed by~~ Board rules ~~or by statute upon~~ and statutes applicable to all other psychologists licensed under this ~~Article.~~Article. These requirements apply regardless of whether the person holds himself or herself out to the public by any title or description stating or implying that the person is a psychologist, a licensed psychological associate, or licensed to practice psychology."

SECTION 3. G.S. 90-270.6 reads as rewritten:

"**§ 90-270.6. Psychology Board; appointment; term of office; composition.**

For the purpose of carrying out the provisions of this Article, there is created a North Carolina Psychology Board, which shall consist of seven members appointed by the Governor. At all times three members shall be licensed psychologists, two members shall be licensed psychological associates, and two members shall be members of the

public who are not licensed under this Article. ~~Each member of the Board must reside in a different congressional district at the time of the appointment. Due~~ The Governor shall give due consideration ~~shall also be given~~ to the adequate representation of the various fields and areas of practice of ~~psychology.~~psychology and to adequate representation from various geographic regions in the State. Terms of office shall be three years. All terms of service on the Board expire June 30 in appropriate years. As the term of a psychologist member expires, or as a vacancy of a psychologist member occurs for any other reason, the North Carolina Psychological Association, or its successor, shall, having sought the advice of the chairs of the graduate departments of psychology in the State, for each vacancy, submit to the Governor a list of the names of three eligible persons. From this list the Governor shall make the appointment for a full term, or for the remainder of the unexpired term, if any. Each Board member shall serve until his or her successor has been appointed. As the term of a member expires, or if one should become vacant for any reason, the Governor shall appoint a new member within 60 days of the vacancy's occurring. No member, either public or licensed under this Article, shall serve more than three complete consecutive terms."

SECTION 4. G.S. 90-270.13(a) reads as rewritten:

"(a) Upon application and payment of the ~~requisite~~ required fee, the Board shall grant permanent licensure at the appropriate level to any person who, at the time of ~~application, is~~ application meets all of the following requirements:

(1) Is licensed or certified as a psychologist by a similar psychology licensing board in another ~~jurisdiction, whose~~ jurisdiction.

(2) The license or certification is in good ~~standing, who is~~ standing.

(3) Is a graduate of an institution of higher ~~education, who passes any~~ education.

(4) Who passes an examination prescribed by the ~~Board, and who meets~~ Board.

(5) Meets the definition of a senior psychologist as that term is defined by the rules of the Board."

SECTION 5. G.S. 90-270.13 is amended by adding a new subsection to read:

"(a1) Upon application and payment of the required fee, the Board shall grant permanent licensure at the appropriate level to any person who, at the time of application meets all of the following requirements:

(1) Is licensed or certified as a psychologist by a similar psychology licensing board in another jurisdiction.

(2) The license or certification is in good standing.

(3) Possesses a doctoral degree in psychology from an institution of higher education.

(4) Passes an examination prescribed by the Board.

(5) Has no unresolved complaints in any jurisdiction at the time of application in this State.

(6) Holds a current credential for psychology licensure mobility, as defined in rules adopted by the Board."

SECTION 6. G.S. 270.13(f) reads as rewritten:

"(f) The Board may deny licensure to any person otherwise eligible for permanent licensure under this ~~subsection~~ section upon documentation of ~~illegal, immoral, dishonorable, unprofessional, or unethical~~ conduct ~~as~~ specified in G.S. 90-270.15."

SECTION 7. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Senate Health Care — **June 20, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Henderson	NCOTA, NCAOTA
Kelly Bryant	Rep Newton's Intern
Ben Thompson	NCBM&BT
V. Gilchrist	"doc of day" ECU - BSOM
Andrew Gilchrist-Scott	son of ↑
Jessica S. Thomas	National MS Society
Mary Sheperis	Counsel Hrng. Aid Bd.
John Sexton	President, NC Hrng Aid Bd.
Rhonda Sinclair	National MS Society
Alan Beauregard	Rep. Fisher
	House Page

VISITOR REGISTRATION SHEET

Senate Health Care — **June 20, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephanie Hackler	National Multiple Sclerosis Society
Luanne Kinkland	National Multiple Sclerosis Society
Stanley D. Rappaport	National Multiple Sclerosis Society
Billy Collins	North Carolina Medical Society (NCMS)
Scott Berger MD	NCMS
Richard Pencheon	NCMS
Judy McConnell	NCMS
Logan Stewart	National Multiple Sclerosis Society
Burton J. Mattice	Carolina Donor Services
Bruce Nicely	Carolina Donor Services
Fred Jordan	North Carolina Eye Bank

VISITOR REGISTRATION SHEET

Senate Health Care — **June 20, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harrison Welch	House Page
Sawyer Faulkner	House Page
[illegible]	House Page
Tommy Suter	Wyeth
Ann Ware	Duke
Jamal Jones	NCAHP
Caroline Lee	Wake County Human Services
Jon Carr	NC Funeral Directors Assoc.
Kevin Leonard	WCSR
Rick Beare	NCAHCP
Sharon H Campbell	National Multiple Sclerosis Society

VISITOR REGISTRATION SHEET

Senate Health Care — **June 20, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pete Jarvis	Gov office
Gordon Keath	Project Challenge NC/JJTC
Elizabeth Landwehr MD	NCMS
Joan Potter M.D.	NCMS
Jodie Moss	NCMS
Kristen Shipherd	NCMS
Chris Burton	NASS
Sondra Panico	NC Dept of Justice
Sally Cameron	NC Psychological Assoc

VISITOR REGISTRATION SHEET

Senate Health Care — **June 20, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Wickham	Lobbyist Raleigh NC
J Craig Jones	NHS

Senate Health Care Committee
Wednesday, June 27, 2007, 11:00 AM
Room 544, Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 973	**Mental Health Equitable Coverage.**	**Representative Holliman Representative Alexander Representative Insko Representative Wainwright**
HB 1294	**No Smoking/LTC Facilities.**	**Representative Justice Representative Howard**
SB 1314	**Amend Massage & Bodywork Therapy Act.**	**Senator Cowell**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, June 27, 2007 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 27, 2007, in Room 544 of the Legislative Office Building, with fifteen members present. Senator Stan Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members and introduced the pages and sergeants-at arms.

Senator Bingham asked for a motion to hear the PCS for HB 973, ***Mental Health Equitable Coverage***. Sen. Dr. Forrester offered the motion, which passed. Sen. Bingham stated he needed to do some housekeeping, pointing out to the committee that they would be hearing the original bill to begin with, so he asked for a motion to reconsider the adoption of the PCS. Sen. Forrester made the motion and Rep. Alexander was asked to present the original bill. Rep. Alexander started the discussion by stating they had waited a long time for this bill to come to the Senate and that it would provide full parity for mental illness. Rep. Alexander clarified that substance abuse was not in the bill as it stands. This bill had the support of both the Mental Health and Medical Communities. Rep. Alexander stated that this bill with full coverage for Mental Illness would cost 13 million dollars and with limited coverage it would be 9.5 million dollars. John Tote, Executive Director of the Mental Health Association of NC, which is the state's oldest and largest mental health advocacy organization, stated this was truly a historic opportunity for our state and this body. Mr. Tote explained that mental illness is real, but it is eminently treatable. Of what is known about the human mind, 95% has been learned in the last twelve years, which was a staggering statistic. No other major health issues have made the advances in treatment and technologies through its research that this health area has. In addition to being real and treatable, the cost is no longer a legitimate factor. The actuarial studies have put the cost at $1.00 - $2.00 per person per month. Sen. Bingham recognized Dr. Jack Naftel, Director of Child and Adolescent Psychiatry at UNC School of Medicine. Dr. Naftel stated that if the bill would include full parity for children, with no limit on diagnoses, it would make a huge difference. Senator Kinnaird stated she had three amendments. She first offered amendment H973-ARC-52, and then Senator Hoyle asked to speak. He stated he had delayed offering a Proposed Committee Substitute until the bill sponsor could present her bill and let the folks testify that wanted to, but now he would like to present his PCS in order not to have to go through three amendments. He stated the committee would have the opportunity to vote the bill up or down or the PCS up or down. Senator Hoyle stated he certainly supported helping people that fall through the cracks with mental problems that are not brought on by them. Senator Hoyle pointed out that when you talk about health care you talk about cost, which goes up and up and up. The people proposing the bill do not think the cost is very much but the people on the other side who are faced with paying the bill have a totally different number that is a multiple of 20, 30, 40, even 50 times the numbers that are proposed. Senator Hoyle expressed he could not support any kind of assessment on small business, state employees or on people who are doing the best they can. He also

pointed out that if you have more benefits it means more cost and that premiums are going to go up. He wanted to make sure that something was not passed at a cost that could not be afforded. The PCS extends benefits to the people with the most severe mental illness, stating there were nine illnesses and the cost was something that could reasonably be afforded. Kory Goldsmith stated the PCS was H973-CSRD-36 [v7]. Sen. Blake asked why it had taken so long for this bill to get to here. Representative Alexander responded that the bill began in 1993 when someone came to her office stating there was a problem in the state with mental illness. As the years went by people looked into this issue and realized there was a major problem. In 1997 the senate passed a companion bill after substance abuse was removed, however the house could not get the bill out until now. The opposition to this bill has been from the insurance companies and small businesses. They have felt like the bill would break the bank and the state. Senator Kinnaird asked to withdraw her amendment. Sen. Bingham stated that Sen. Forrester had earlier made the motion to hear the PCS. Ben Popkins stated the first difference between the bill and the PCS was the PCS applied to all group health plans instead of the 25-employ threshold. The PCS listed nine mental illnesses that have to be covered identically with any physical illness, including co-payments, deductibles, and other. For all other mental illnesses it establishes a minimum benefit package and coverage of benefits. The limits would be as with other illnesses. However, durational limits would be different, i.e. thirty days of in-patient or outpatient days per year and an additional thirty office visits per year. The insurer could increase these limits at their discretion. Sen. Forrester said this would not cover half the insurers in the state due to The Employee Retirement Income Security Act of 1974 (ERISA). ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry. The state laws cannot change ERISA. Small businesses are the ones that will be affected. Sen. Forrester suggested the Co- Chairs put this in a Sub-Committee. Sen. Bingham stated they would go on with the discussion. Sen. Malone pointed out he had looked at the information and knew it had been there for 14 years and felt the PCS was a good start. Senator Berger supported the PCS to cover all employees, with the exception of the folks under ERISA. Sen. Berger moved for a favorable report for the PCS and unfavorable to original bill at the appropriate time. Sen. Allran stated mental illnesses and physical illnesses could not be separated and questioned how the nine categories were picked. Ben Popkins reiterated he wanted to make clear the illnesses other than the nine are covered and the benefits are to be at least as rich as the other illnesses; the only difference is the duration. There are limited durations for the illnesses not included in the nine illnesses. Sen. Allran asked how they came up with the nine; was it the doctors or businesses? Ken Wright with BlueCross BlueShield of NC stated the nine illnesses were chosen because other states used the same SMIs (severe mental illness). Senator Allran asked if it would save money if we would address mental illnesses. Dr. Don Bradley, Chief Medical Officer for BlueCrosss BlueShield of NC, stated that 18 years ago the mental health bed days were over 100 per 1000 and currently they are 13 – 25 per 1000. Dr. Bradley stated there were two things that happened; first was Managed Mental Health, and second was Benefit Limits. To determine the nine benefits, they looked at where people exhausted their benefits so those could be included

in the nine. Sen. Allran asked about the other states and if it had been economically good for them. Dr. Jack Naftle with UNC Hospital stated that it was true mental health care had gone down, but if you look at our own state health plan it has been consistently 2% or less of the total health cost dollars and it has been an unmanaged plan without the nine diagnoses. Sen. Bingham stated they were out of time and there already was a motion from Senator Berger, unfavorable as to bill but favorable as to the Committee Substitute Bill. The vote was taken and passed.

The meeting adjourned at 12:02 P.M.

Senator Stan Bingham, Co-Chair

Senator Dr. William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, June 28, 2007

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **973** Mental Health Equitable Coverage.

Draft Number:	50721
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 4

HOUSE BILL 973

Committee Substitute Favorable 5/8/07
Committee Substitute #2 Favorable 5/22/07
Fourth Edition Engrossed 5/23/07

Short Title: Mental Health Equitable Coverage. (Public)

Sponsors:

Referred to:

March 22, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE EQUITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against ~~the~~ mentally ill and chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(b1) Coverage of Mental Illness. A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:~~

~~(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.~~

~~(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(4) Except as otherwise provided in this section, the policy may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the policy, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.~~

~~(5) If the insurer offers two or more benefit package options under a policy, each package must comply with this subsection.~~

~~(6) This subsection does not apply to a policy if the insurer can demonstrate to the Commissioner that compliance will increase the cost of the policy by one percent (1%) or more.~~

~~(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.~~

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires an insurer to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-51-50.

(d) Applicability. – ~~Subsection (b1) of this~~This section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than ~~50~~25 employees. ~~The remainder of this section applies only to group health insurance contracts covering 20 or more employees.~~ For purposes of this

section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a)."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Health Equity Requirement. – An insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Average. – If a health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(d) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167 and includes the Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) and the Plan's optional PPO program.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(e) Applicability. – This section applies only to group health benefit plans covering more than 25 employees."

SECTION 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against ~~the~~—mentally ill and chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. – No service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(b1) Coverage of Mental Illness. – A subscriber contract that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:~~

~~(1) A lifetime limit or annual limit may be made applicable to all benefits under the subscriber contract, without distinguishing the mental health benefits.~~

~~(2) If the subscriber contract contains lifetime limits only on selected physical illness or injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(3) If the subscriber contract contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the subscriber contract, the service corporation may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and~~

~~injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(4) Except as otherwise provided in this section, the subscriber contract may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the subscriber contract, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.~~

~~(5) If the service corporation offers two or more benefit package options under a subscriber contract, each package must comply with this subsection.~~

~~(6) This subsection does not apply to a subscriber contract if the service corporation can demonstrate to the Commissioner that compliance will increase the cost of the subscriber contract by one percent (1%) or more.~~

~~(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.~~

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires a service corporation to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-65-75.

(d) Applicability. ~~Subsection (b1) of this~~ This section applies only to subscriber contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than ~~50~~ 25 employees. ~~The remainder of this section applies only to group contracts covering 20 or more employees.~~"

SECTION 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against ~~the~~ mentally ill and chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9) and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. – No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

~~(b1) Coverage of Mental Illness. – A health care plan that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:~~

~~(1) A lifetime limit or annual limit may be made applicable to all benefits under the plan, without distinguishing the mental health benefits.~~

~~(2) If the plan contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(3) If the plan contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the HMO may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.~~

~~(4) Except as otherwise provided in this section, the plan may distinguish between mental illness benefits and physical injury or illness benefits with respect to other terms of the plan, including coinsurance, limits on provider visits or days of coverage, and requirements relating to medical necessity.~~

~~(5) If the HMO offers two or more benefit package options under a plan, each package must comply with this subsection.~~

~~(6) This subsection does not apply to a health benefit plan if the HMO can demonstrate to the Commissioner that compliance will increase the cost of the plan by one percent (1%) or more.~~

~~(7) This subsection expires October 1, 2001, but the expiration does not affect services rendered before that date.~~

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires an HMO to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-67-70.

(d) Applicability. – ~~Subsection (b1) of this~~ This section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than ~~50~~ 25 employees. ~~The remainder of this section applies only to group contracts covering 20 or more employees.~~"

SECTION 5. G.S. 58-50-155 reads as rewritten:

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

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

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

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

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

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(7) Treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. Nothing in this subdivision prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

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

SECTION 6. This act becomes effective January 1, 2008, and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 973

Committee Substitute Favorable 5/8/07
Committee Substitute #2 Favorable 5/22/07
Fourth Edition Engrossed 5/23/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H973-CSRD-36 [v.7]

6/26/2007 8:06:12 PM

Short Title: Mental Health Equitable Coverage. (Public)

Sponsors:

Referred to:

March 22, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE MANDATORY HEALTH INSURANCE COVERAGE OF CERTAIN MENTAL ILLNESSES AND TO REQUIRE AT LEAST A MINIMUM BENEFIT PACKAGE FOR OTHER MENTAL ILLNESSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against ~~the~~ mentally ill ~~and~~ or chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~ 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

~~with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.~~

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires an insurer to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-51-50.

(d) Applicability. – ~~Subsection (b1) of this~~ This section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.~~ For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Health Equity Requirement. – Except as provided in subsection (b), an insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally, including application of the same limits. For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes. For purposes of this subsection, 'limits' includes deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Minimum Required Benefits. – Except as provided in subsection (c), a group health benefit plan may apply durational limits to mental illnesses that differ from durational limits that apply to physical illnesses. A group health benefit plan shall provide at least the following minimum number of office visits and combined inpatient and outpatient days for all mental illnesses and disorders not listed in subsection (c), as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders,

DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes:

(1) Thirty (30) combined inpatient and outpatient days per year.

(2) Thirty (30) office visits per year.

(c) Durational limits for the following mental illnesses shall be subject to the same limits as benefits for physical illness generally:

(1) Bipolar Disorder.

(2) Major Depressive Disorder.

(3) Obsessive Compulsive Disorder.

(4) Paranoid and Other Psychotic Disorder.

(5) Schizoaffective Disorder.

(6) Schizophrenia.

(7) Post-Traumatic Stress Disorder.

(8) Anorexia Nervosa.

(9) Bulimia.

(d) Nothing in this section prevents an insurer from offering a group health benefit plan that provides greater than the minimum required benefits, as set forth in subsection (b).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care.

(f) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the group health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(g) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(h) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders

coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes."

SECTION 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against ~~the~~ mentally ill ~~and~~ or chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes .

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~ 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

~~with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.~~

(b) Coverage of Physical Illness. – No service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires a service corporation to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-65-75.

(d) Applicability. – This ~~Subsection (b1) of this~~ section applies only to ~~subscriber~~ group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~ For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care."

SECTION 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against ~~the~~ mentally ill ~~and~~ or chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-67-70~~ 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

~~with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.~~.

(b) Coverage of Physical Illness. – No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires an HMO to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-67-70.

(d) Applicability. – ~~Subsection (b1) of this~~ This section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~ For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care."

SECTION 5. G.S. 58-50-155 reads as rewritten:

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

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

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

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

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

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(7) Treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. Nothing in this subdivision prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

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

SECTION 6. This act becomes effective July 1, 2008, and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

HOUSE BILL 973:
Mental Health Equitable Coverage

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 24, 2007
Introduced by:	Reps. Alexander, Holliman, Wainwright, Insko	**Summary by:**	Kory Goldsmith Staff Attorney
Version:	Fourth Edition		

SUMMARY: House Bill 973 would amend existing insurance law to require that group health benefit plans covering more than 25 employees provide coverage for treatment of mental illness services according to the same limits applicable to that benefit plan's coverage of physical illness or injury.

HB 973 would enact a new section in Article 3 (General Regulations for Insurance) of Chapter 58 (Insurance) that would require insurers that provide group health benefit plans covering more than 25 employees to provide mental illness benefits that "...are no less favorable than benefits for physical illness generally."

HB 973 would also amend Articles 51 (Nature of Policies), 65 (Hospital, Medical and Dental Service Corporations) and 67 (Health Maintenance Organization Act) of Chapter 58 to enact new provisions governing non-discrimination against mentally ill individuals.

CURRENT LAW: There is no current statutory requirement that group benefit plans offer coverage for mental illness services.

Existing language in Articles 51, 65 and 67 of Chapter 58 prohibits discrimination against individuals with mental illness (may not reduce policy benefits for physical illness treatment, raise premium rates for physical illness coverage, or refuse to issue a policy for physical illness coverage solely because of the person's mental illness or chemical dependency).

Existing statutory language requiring policies that provide benefits for both physical and mental illness to provide equal annual and lifetime coverage benefits for mental illness benefits as for physical illness benefits sunset on October 1, 2001.

BILL ANALYSIS: House Bill 973 would amend Articles 51, 65 and 67 of Chapter 58 of the General Statutes to require that every group health benefit plan covering more than 25 employees provide coverage for treatment of mental illness services according to the same limits applicable to that benefit plan's coverage of physical illness treatment.

HB 973 would enact a new G.S. 58-3-220 "Mental illness benefits coverage" that would create a "Mental Health Equity Requirement", directing insurers to provide group health plan benefits for "...the necessary care and treatment of mental illness...no less favorable than benefits for physical illness generally." This new section would make benefits for treatment of mental illness subject to the same limits as benefits for physical illness. G.S. 58-3-220 would also include:

- Limits – would include durational limits, deductibles, coinsurance factors, co-payments, maximum out of pocket limits, and annual and lifetime dollar limits.
- Weighted average – group health benefit plans placing limits only on selected physical illness and injury benefits may impose limits on mental illness benefits based on a weighted

average of the limits placed on the physical illness benefits (calculated in accordance with rules adopted by the Commissioner).

- Utilization review to determine medical necessity.
- Applicability. – The provisions would apply if the employer has more than 25 employees.

HB 973 would also amend G.S. 58-50-155 to add treatment for mental illness to the existing list of treatments or services for which coverage by 'standard health plans' is required.

EFFECTIVE DATE: This act becomes effective January 1, 2008, and would apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date.

Ben Popkin, counsel to House Health Committee, substantially contributed to this summary.

H0973e4-SMRC

HOUSE BILL 973:
Mental Health Equitable Coverage

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 26, 2007
Introduced by:	Reps. Alexander, Holliman, Wainwright, Insko	**Summary by:**	Ben Popkin Committee Counsel
Version:	PCS to Fourth Edition H973-CSRD		

SUMMARY: ***House Bill 973 would amend existing insurance law to require that group health benefit plans covering more than 25 employees provide coverage for treatment of mental illness services according to the same limits applicable to that benefit plan's coverage of physical illness or injury. HB 973 would enact a new section in Article 3 (General Regulations for Insurance) of Chapter 58 (Insurance) that would require insurers that provide group health benefit plans covering more than 25 employees to provide mental illness benefits that "...are no less favorable than benefits for physical illness generally." HB 973 would also amend Articles 51 (Nature of Policies), 65 (Hospital, Medical and Dental Service Corporations) and 67 (Health Maintenance Organization Act) of Chapter 58 to enact new provisions governing non-discrimination against mentally ill individuals.***

The Proposed Committee Substitute to House Bill 973 would revise the original bill as follows:

-Remove the 25 employee threshold so the bill would apply to all group health plans.

-Identify nine specific mental illnesses for which plan benefits must be at least as favorable as for physical illnesses and for which plan limits must be the same as for physical illnesses.

-Require that plan benefits and all but durational limits for 'other mental illnesses' (those not included among the nine listed) also be at least as favorable as for physical illnesses.

-Establish t he following minimum required benefits for annual durational limits which may be imposed on 'other mental illnesses': 30 combined inpatient and outpatient days, and 30 office visits.

-Exclude "sexual dysfunctions not due to organic disease" (DSM codes 302.70 through 302.79) from the disorders included within the definition of 'mental illness' for purposes of plan coverage.

-New provision stating that the provisions of the bill would not require insurers to "...cover treatment or studies leading to or in connection with sex changes or modifications..."

-Remove the State Health Plan from the definition of 'health benefit plan'.

-Change effective date from January 1, 2008 to July 1, 2008.

CURRENT LAW: There is no current statutory requirement that group benefit plans offer coverage for mental illness services.

Existing language in Articles 51, 65 and 67 of Chapter 58 prohibits discrimination against individuals with mental illness (may not reduce policy benefits for physical illness treatment, raise premium rates for physical illness coverage, or refuse to issue a policy for physical illness coverage solely because of the person's mental illness or chemical dependency).

Existing statutory language requiring policies that provide benefits for both physical and mental illness to provide equal annual and lifetime coverage benefits for mental illness benefits as for physical illness benefits sunset on October 1, 2001.

BILL ANALYSIS: House Bill 973 would amend Articles 51, 65 and 67 of Chapter 58 of the General Statutes to require that every group health benefit plan covering more than 25 employees provide coverage for treatment of mental illness services according to the same limits applicable to that benefit plan's coverage of physical illness treatment.

HB 973 would enact a new G.S. 58-3-220 "Mental illness benefits coverage" that would create a "Mental Health Equity Requirement", directing insurers to provide group health plan benefits for "...the necessary care and treatment of mental illness...no less favorable than benefits for physical illness generally." This new section would make benefits for treatment of mental illness subject to the same limits as benefits for physical illness. G.S. 58-3-220 would also include:

- Limits – would include durational limits, deductibles, coinsurance factors, co-payments, maximum out of pocket limits, and annual and lifetime dollar limits.
- Weighted average – group health benefit plans placing limits only on selected physical illness and injury benefits may impose limits on mental illness benefits based on a weighted average of the limits placed on the physical illness benefits (calculated in accordance with rules adopted by the Commissioner).
- Utilization review to determine medical necessity.
- Applicability – The provisions would apply if the employer has more than 25 employees.

HB 973 would also amend G.S. 58-50-155 to add treatment for mental illness to the existing list of treatments or services for which coverage by 'standard health plans' is required.

The Proposed Committee Substitute to House Bill 973 would make the following changes to HB 973:

- Remove the 25 employee threshold so the bill would apply to all group health plans.
- Identify nine specific mental illnesses for which plan benefits must be at least as favorable as for physical illnesses and for which plan limits must be the same as for physical illnesses.
- Require that plan benefits and all but durational limits for 'other mental illnesses' (those not included among the nine listed) also be at least as favorable as for physical illnesses.
- Establish the following minimum required benefits for annual durational limits which may be imposed on 'other mental illnesses': 30 combined inpatient/outpatient days, & 30 office visits.
- Exclude "sexual dysfunctions not due to organic disease" (DSM codes 302.70 through 302.79) from the disorders included within the definition of 'mental illness' for purposes of plan coverage.
- Insert new provisions throughout the bill stating that the bill would not require insurers to "...cover treatment or studies leading to or in connection with sex changes or modifications...".
- Remove the State Health Plan from the definition of 'health benefit plan'.
- Change the effective date from January 1, 2008 to July 1, 2008.

EFFECTIVE DATE: This act becomes effective July 1, 2008, and would apply to health benefit plans that are delivered, issued for delivery, or renewed on or after that date.

Kory Goldsmith, counsel to House Insurance, substantially contributed to this summary.

H0973e4-SMRD-CSRD

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 973

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

H973-ARC-52 [v.1]

Date _____,2007

Comm. Sub. [NO]
Amends Title [NO]
Fourth Edition

Senator Kinnaird

moves to amend the bill on page 2, lines 40-43, by rewriting the lines to read:

"(d) Applicability. – ~~Subsection (b1) of this~~This section applies only to group health insurance contracts, other than excepted benefits as defined in ~~G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.~~ G.S. 58-68-25. For purposes of this";

and on page 3, by deleting lines 39-40;

and on page 5, lines 20-23, by rewriting the lines to read:

"~~(d) Applicability. Subsection (b1) of this section applies only to subscriber contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~";

and on page 6, lines 40-43, by rewriting the lines to read:

"~~(d) Applicability. Subsection (b1) of this section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than~~

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 973

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

H973-ARC-52 [v.1]

~~50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

What have States Done to Ensure Insurance Parity?

National Mental Health Association

Best Parity Laws

Parity applies to all mental health and substance abuse disorders under private insurance plans. No exemptions.

Connecticut 1999

Maryland 1994

Minnesota 1995

Vermont 1997

Oregon 2005 **Will not take effect until 2007*

Good Parity Laws

Not quite comprehensive parity due to certain exemptions and/or limitations.

Indiana 1999/2001/2003
Includes substance abuse; 50 employees exemption; 4% cost increase cap

Kentucky 2000
50 employees exemption; includes substance abuse

Maine 1995/ 2004
20 employees exemption; includes substance abuse (Except V-Codes)

New Mexico 2000
No substance abuse; 1.5% cost increase cap for less than 50 employees & 2.5% for 50 or more employees

Rhode Island 1994/2001
Some limitations on outpatient visits; includes substance abuse

Washington 2005
50 employees exemption; No substance abuse

Limited Parity Laws

Parity applies only to select groups such as those with severe mental illness (SMI) or state & local employees, or only protects against certain types of discrimination.

Arizona 1997/2001
Mirrors federal law; 50 employees exemption; 1% cost increase cap; parity for state employees

Arkansas 1997/2001
50 employees exemption; 1.5% cost increase cap; excludes state employees; full parity in SCHIP

California 1999 (SMI)
Includes children with serious emotional disorders

Colorado 1997 (SMI)

Delaware 1998/2001 (SMI)
Includes substance abuse

Hawaii 2004 (SMI)
25 employees exemption; Includes substance abuse treatment.

Illinois 2001 (SMI)
50 employees exemption

Iowa 2005 (SMI)
50 employees exemption

Louisiana 1999 (SMI)
Includes children

Massachusetts 2000 (SMI)
50 employees exemption; includes children & co-occurring disorders

Missouri 2004
Limits out-of-pocket expenses

Montana 1999 (SMI)

Nebraska 1999 (SMI)
15 employees exemption

New Hampshire 1994/2002 (SMI)

Nevada 1999 (SMI)
Limits out-of-pocket expenses; 25 employees exemption

Limited Parity Laws

New Jersey 1999/2002 (SMI)

North Carolina 1991/1997
1991: Comprehensive parity for state & local employees/1997: mirrors federal law; 50 employees exemption; 1% cost increase cap

Oklahoma 1999 (SMI)
50 employees exemption; 2% cost increase cap

South Carolina 2000/2005 (SMI)
50 employees exemption

South Dakota 1998 (SMI)

Texas 1991/1997 (SMI)
1991: Limited parity for state & local government employees
1997: parity expanded to rest of state; 50 employees exemption

Tennessee 1998
25 employees exemption; 1% cost increase cap; excludes copayments, coinsurance and deductibles

Utah 2000
Limits out-of-pocket expenses; 50 employees exemption

Virginia 2004 (SMI)
Includes substance abuse; 25 employees exemption

West Virginia 2004 (SMI)
2004 repealed alcohol coverage; 1 or 2% cost-increase cap

Mental Health Mandates, Not Parity

Alabama	Alaska	D.C.
Florida	Georgia	Kansas
Michigan	Mississippi	Ohio
Pennsylvania	New York	North Dakota
Wisconsin		

No Parity or Mandate Laws

Idaho	Wyoming

Updated September 2005

Mental Health Association
in North Carolina, Inc.
1331 Sunday Drive • Raleigh, NC 27607 • (919) 981-0740 • Fax: (919) 954-7238
TDD 800-735-2962

PRESENTATION TO SENATE HEALTH COMMITTEE ON
MENTAL HEALTH EQUITABLE COVERAGE
JUNE 27, 2007

Mr. Chairman, Members of the Committee, thank you for this opportunity to present on this important issue.

My name is John Tote. I am the Executive Director of the Mental Health Association in N.C. We are our state's oldest and largest mental health advocacy organization representing the needs and issues of the millions of North Carolinians directly affected by mental illness and their families.

We gather on this steamy summer day to work on a vital piece of legislation for the well-being of our state's citizens. Indeed, this is an historic time for our state and for our mental health community.

A decade ago, in 1997, this body passed a comprehensive mental health parity bill. Unfortunately, that piece of legislation died in the House. Now, a decade later in 2007, the House of Representatives has passed its own version of mental health parity. This unanimously passed two House committees. Today you have the opportunity to continue on the path of justice and fairness for our citizens by passing your version of mental health parity.

Quite frankly, opponents of this bill are simply out of ammunition. First of all, mental illness is real but it is imminently treatable. What we know of the human mind, we have learned 95% of it in the last 12 years. That is a staggering statistic. No other major health issue has made the advances in treatment and technology through its research than in this area. In addition to being real and treatable the cost is no longer a legitimate factor. Actuarial studies have put the cost somewhere between a dollar to two dollars per person per month. Yet real life experience in the state with the most comprehensive mental health parity legislation shows that it costs nineteen cents per month. Here is a quarter, keep the change.

We in the advocacy community strongly believe that your version of mental health parity should be comprehensive. While it will not include substance abuse, we hope that one day it will. We believe that you should not go with a list of diagnoses, but rather include all forms of mental illness in your bill. Incidentally, the Vermont legislation that I referenced earlier for nineteen cents a month, not only was it comprehensive mental health parity, it was also substance abuse parity.

This benefit extension will do wonders for the needs of our state. Two specific areas to consider as legislators beyond what we believe is the moral implication, i.e. the right thing to do, is to pass this piece of legislation. From a policy standpoint, please keep in mind that you are already paying to not have mental health parity in this state. The cost shift from the private sector to the public sector cannot be ignored. It also must be said that because there is no parity in the private sector people are made to get worse before we can try to get them better by sending severely ill individuals to the public sector when they could have been treated more effectively and humanely, as well as cost-effectively, earlier on.

Lastly, each of you sitting around this table and your peers in the General Assembly, along with teachers, state employees, and the Governor have had access to mental health parity since 1992 through the state health plan. You have also had access to substance abuse parity since 1997 due to the same plan. The data that we have seen from the Our State Health Plan as well as other mental health equitable bills across the country is staggering and cannot be ignore. The time is now. This is the right thing to do and this is just good business.

Thank you.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 973

Committee Substitute Favorable 5/8/07
Committee Substitute #2 Favorable 5/22/07
Fourth Edition Engrossed 5/23/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H973-PCS50721-RD-36

Short Title: Mental Health Equitable Coverage. (Public)

Sponsors:

Referred to:

March 22, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE MANDATORY HEALTH INSURANCE COVERAGE OF CERTAIN MENTAL ILLNESSES AND TO REQUIRE AT LEAST A MINIMUM BENEFIT PACKAGE FOR OTHER MENTAL ILLNESSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against ~~the~~ mentally ill ~~and~~ or chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-51-50~~ 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

~~with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.~~

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires an insurer to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-51-50.

(d) Applicability. – ~~Subsection (b1) of this~~ This section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.~~ For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Health Equity Requirement. – Except as provided in subsection (b), an insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally, including application of the same limits. For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes. For purposes of this subsection, 'limits' includes deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Minimum Required Benefits. – Except as provided in subsection (c), a group health benefit plan may apply durational limits to mental illnesses that differ from durational limits that apply to physical illnesses. A group health benefit plan shall provide at least the following minimum number of office visits and combined inpatient and outpatient days for all mental illnesses and disorders not listed in subsection (c), as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders,

DSM-IV, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes:

(1) Thirty combined inpatient and outpatient days per year.

(2) Thirty office visits per year.

(c) Durational limits for the following mental illnesses shall be subject to the same limits as benefits for physical illness generally:

(1) Bipolar Disorder.

(2) Major Depressive Disorder.

(3) Obsessive Compulsive Disorder.

(4) Paranoid and Other Psychotic Disorder.

(5) Schizoaffective Disorder.

(6) Schizophrenia.

(7) Post-Traumatic Stress Disorder.

(8) Anorexia Nervosa.

(9) Bulimia.

(d) Nothing in this section prevents an insurer from offering a group health benefit plan that provides greater than the minimum required benefits, as set forth in subsection (b).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care.

(f) Weighted Average. – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the group health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(g) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(h) Definitions. – As used in this section:

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-167.

(2) 'Insurer' has the same meaning as in G.S. 58-3-167.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders

coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes."

SECTION 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against ~~the~~ mentally ill ~~and~~ or chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes .

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-65-75~~ 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

~~with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.~~

(b) Coverage of Physical Illness. – No service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires a service corporation to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-65-75.

(d) Applicability. – This ~~Subsection (b1) of this~~ section applies only to ~~subscriber~~ group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~ For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care."

SECTION 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against ~~the~~ mentally ill ~~and~~ or chemically ~~dependent.~~dependent individuals.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in ~~G.S. 122C-3(21); and~~G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-IV or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as 'V' codes.

(2) 'Chemical dependency' has the same meaning as defined in G.S. ~~58-67-70~~ 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or subsequent editions published by the American Psychiatric Association.

~~with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.~~.

(b) Coverage of Physical Illness. – No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) ~~Mental Illness or~~ Chemical Dependency Coverage Not Required. – Nothing in this section requires an HMO to offer coverage for ~~mental illness or~~ chemical dependency, except as provided in G.S. 58-67-70.

(d) Applicability. – ~~Subsection (b1) of this~~ This section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25. ~~58-68-25, covering more than 50 employees. The remainder of this section applies only to group contracts covering 20 or more employees.~~ For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care."

SECTION 5. G.S. 58-50-155 reads as rewritten:

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

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

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

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

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

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(7) Treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. Nothing in this subdivision prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

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

SECTION 6. This act becomes effective July 1, 2008, and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after that date. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 1294

Committee Substitute Favorable 4/26/07

Committee Substitute #2 Favorable 5/10/07

Short Title: No Smoking/LTC Facilities. (Public)

Sponsors:

Referred to:

April 4, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING INSIDE LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.4 reads as rewritten:

"**§ 131D-4.4. Adult care home minimum safety ~~requirements.~~requirements; smoking prohibited inside long-term care facilities; penalty.**

(a) In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

(b) Smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (c) of this section."

SECTION 2. Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.**

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section."

SECTION 3. Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-6. Smoking prohibited; penalty.**

(a) Smoking is prohibited inside facilities licensed under this Chapter and inside State psychiatric hospitals. As used in this section, 'smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, 'inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section."

SECTION 4. Part 3 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-143. Smoking prohibited; penalty.**

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

(1) 'Employee' includes an individual under contract with the home care agency to provide home care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section."

SECTION 5. This act is effective when it becomes law and applies to violations committed on and after that date. G.S. 131D-4.4(c)(3), 131E-114.3(b)(3), and 122C-6(b)(3), as enacted by this act, apply to individuals admitted to the facility on and after the effective date of this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1294

Committee Substitute Favorable 4/26/07

Committee Substitute #2 Favorable 5/10/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1294-CSRD-29 [v.1]

6/5/2007 4:56:54 PM

Short Title: No Smoking/LTC Facilities. (Public)

Sponsors:

Referred to:

April 4, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING INSIDE LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.4 reads as rewritten:

"**§ 131D-4.4. Adult care home minimum safety ~~requirements.~~requirements; smoking prohibited inside long-term care facilities; penalty.**

(a) In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

(b) Smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No

Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (c) of this section. A violation of subsection (c) of this section constitutes a civil offense only and is not a crime."

SECTION 2. Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.**

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section. A violation of subsection (b) of this section constitutes a civil offense only and is not a crime."

SECTION 3. Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-6. Smoking prohibited; penalty.**

(a) Smoking is prohibited inside facilities licensed under this Chapter and inside State psychiatric hospitals. As used in this section, 'smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, 'inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of subsection (b) of this section constitutes a civil offense only and is not a crime."

SECTION 4. Part 3 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-143. Smoking prohibited; penalty.**

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

(1) 'Employee' includes an individual under contract with the home care agency to provide home care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section. A violation of subsection (a) of this section constitutes a civil offense only and is not a crime."

SECTION 5. This act becomes effective October 1, 2007 and applies to violations committed on or after that date. G.S. 131D-4.4(c)(3), 131E-114.3(b)(3), and 122C-6(b)(3), as enacted by this act, apply to individuals admitted to the facility on or after October 1, 2007.

HOUSE BILL 1294:
No Smoking/LTC Facilities

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 26, 2007
Introduced by:	Reps. Howard, Justice	**Summary by:**	Shawn Parker
Version:	PCS to Third Edition H1294-CSRD		Legislative Analyst

SUMMARY: House Bill 1294 would prohibit smoking inside defined long-term care facilities and would allow the Department of Health and Human Services to impose a penalty of up to $200 per violation on the owner, manager or operator who fails to comply with the law.

The Proposed Committee Substitute would insert language to clarify the fact that violations of the provisions of the act would be civil offenses only and not crimes. The PCS also would establish an effective date of October 1, 2007 rather than the previous 'when it becomes law'.

BILL ANALYSIS: House Bill 1294 would prohibit smoking inside long-term care facilities, including adult care homes, nursing homes, skilled nursing facilities, State psychiatric hospitals, and other licensed facilities that provide long-term care services as defined in the bill. Smoking is defined as the "use or possession of any lighted cigar, cigarette, pipe or other lighted tobacco product."

The owner, manager, or operator of a long-term care facility shall do the following:

(1) conspicuously post a sign stating that smoking is prohibited;

(2) direct any person smoking inside the facility to extinguish any lighted tobacco product; and

(3) provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

The Department of Health and Human Services (Department) would be authorized to impose an administrative penalty of up to $200 per violation on the owner, manager, or operator of the facility not complying with the above provisions.

Home care agencies would prohibit their employees from smoking while providing services in an individual's home. The home care agency would be directed to inform its clients about the prohibition. The Department would be authorized to impose an administrative penalty of up to $200 per violation on the owner, manager, or operator of the home care agency who fails to comply.

EFFECTIVE DATE: The act would become effective October 1, 2007 and would apply to violations committed on or after that date. Notice requirements under the bill apply to individuals admitted to the facility on or after October 1, 2007.

This summary was substantially contributed to by Tim Hovis, Counsel to House Judiciary I.

H1294e3-SMSQ-CSRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1314

Short Title:	Amend Massage & Bodywork Therapy Act.	(Public)
Sponsors:	Senator Cowell.	
Referred to:	Commerce, Small Business and Entrepreneurship.	

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE LAWS UNDER THE NORTH CAROLINA MASSAGE AND BODYWORK THERAPY PRACTICE ACT TO EXPAND THE EXISTING LAWS REGULATING MASSAGE AND BODYWORK THERAPY SCHOOLS; TO AUTHORIZE THE BOARD TO ESTABLISH FEES FOR LICENSING MASSAGE AND BODYWORK THERAPY SCHOOLS; TO ALLOW THE DEPARTMENT OF JUSTICE TO CONDUCT CRIMINAL HISTORY RECORD CHECKS FROM STATE AND NATIONAL REPOSITORIES OF CRIMINAL HISTORY OF APPLICANTS FOR LICENSURE TO PRACTICE MASSAGE AND BODYWORK THERAPY; AND TO AMEND THE EXISTING LAWS REGARDING ADULT ENTERTAINMENT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-621 reads as rewritten:

"**§ 90-621. Declaration of purpose.**

~~The General Assembly recognizes that the improper practice of massage and bodywork therapy is potentially harmful to the public. Mandatory licensure of those engaged in the practice of massage and bodywork therapy is necessary to ensure minimum standards of competency and to protect the public health, safety, and welfare.~~The purpose of this Article is to ensure the protection of the health, safety, and welfare of the citizens of this State receiving massage and bodywork therapy services. This purpose is achieved by establishing standards of education and training to enable each student to master the body of knowledge and demonstrate an accomplished proficiency in the field of massage and bodywork therapy. Mandatory licensure of those engaged in the practice of massage and bodywork therapy assures the public that each individual has satisfactorily met the standards of the profession and continues to meet both the ethical and competency goals of the profession."

SECTION 2. G.S. 90-622 reads as rewritten:

"**§ 90-622. Definitions.**

The following definitions apply in this Article:

(1) Accreditation. – Status granted to a postsecondary institution of higher learning that has met standards set by an accrediting agency recognized by the Secretary of the United States Department of Education. The accreditation for massage and bodywork schools may be institutional or programmatic in nature.

~~(1)~~(1a) Board. – The North Carolina Board of Massage and Bodywork Therapy.

(2) Board-approved school. – Any massage and bodywork therapy school or training program in this State or another state that is not otherwise exempt from Board approval, that has met the ~~criteria established by the Board.~~standards set forth in this Article, and been granted approval by the Board.

(2a) Criminal history record check. – A report resulting from a request made by the Board to the North Carolina Department of Justice for a history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice massage and bodywork therapy. 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.

(2b) Jurisdiction. – The authority, capacity, or right of another state, territory of the United States, District of Columbia, or a foreign country to act.

(3) Massage and bodywork therapy. – Systems of activity applied to the soft tissues of the human body for therapeutic, educational, or relaxation purposes. The application may include:

a. Pressure, friction, stroking, rocking, kneading, percussion, or passive or active stretching within the normal anatomical range of movement.

b. Complementary methods, including the external application of water, heat, cold, lubricants, and other topical preparations.

c. The use of mechanical devices that mimic or enhance actions that may possibly be done by the hands. The application of systems of activity by a massage and bodywork therapist during the course of therapy shall not include any action pursued with the intent of providing sexual stimulation or pursuing sexual contact.

(4) Massage and bodywork therapist. – A person licensed under this Article.

(5) Practice of massage and bodywork therapy. – The application of massage and bodywork therapy to any person for a fee or other consideration. ~~"Practice of massage and bodywork therapy" does not include the diagnosis of illness or disease, medical procedures, chiropractic adjustive procedures, electrical stimulation, ultrasound, prescription of medicines, or the use of modalities for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.~~ The practice of massage and bodywork therapy does not include:

a. The diagnosis of illness or disease.

b. Medical procedures, chiropractic adjustive procedures, electrical stimulation, ultrasound, or prescription of medicines.

c. The use of modalities for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.

d. Sexual activity, which shall mean any direct or indirect physical contact or verbal communication, by any person or between persons, which is intended to erotically stimulate either person, or which is likely to cause such stimulation and includes sexual intercourse, fellatio, cunnilingus, masturbation, or anal intercourse. As used in this sub-subdivision, masturbation means the manipulation of any body tissue with the intent to cause sexual arousal. Sexual activity can involve the use of any device or object and is not dependent on whether penetration, orgasm, or ejaculation has occurred."

SECTION 3. G.S. 90-625 reads as rewritten:

"**§ 90-625. North Carolina Board of Massage and Bodywork Therapy.**

(a) The North Carolina Board of Massage and Bodywork Therapy is created. The Board shall consist of seven members who are residents of this State and are as follows:

(1) Five members shall be massage and bodywork therapists who have been licensed under this Article and have been in the practice of massage and bodywork therapy for at least five of the last seven years prior to their serving on the Board. ~~The appointments may be made from lists provided by the North Carolina Therapeutic Massage and Bodywork Task Force.~~ Consideration shall be given to geographical distribution, practice setting, clinical specialty, involvement in massage and bodywork therapy education, and other factors that will promote diversity of the profession on the Board. Two of the five members shall be appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, two shall be appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the Governor.

(2) One member shall be a physician licensed pursuant to Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes or a person once licensed as a physician whose license lapsed while the person was in good standing with the profession and eligible for licensure. The appointment shall be made by the Governor and may be made from a list provided by the North Carolina Medical Society.

(3) One member shall be a member of the general public who shall not be licensed under Chapter 90 of the General Statutes or the spouse of a person who is so licensed, or have any financial interest, directly or indirectly, in the profession regulated under this Article. The appointment shall be made by the Governor.

(b) Legislative appointments shall be made in accordance with G.S. 120-121. A vacancy in a legislative appointment shall be filled in accordance with G.S. 120-122.

(c) Each member of the Board shall serve for a term of three years, ending on June 30 of the last year of the term. A member shall not be appointed to serve more than two consecutive terms.

(d) The Board shall elect annually a chair and other officers as it deems necessary. The Board shall meet as often as necessary for the conduct of business but no less than twice a year. The Board shall establish procedures governing the calling, holding, and conducting of regular and special meetings. A majority of the Board shall constitute a quorum.

(e) Each member of the Board may receive per diem and reimbursement for travel and subsistence as set forth in G.S. 93B-5.

(f) Members may be removed by the official who appointed the member for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings as a licensee or other professional credential shall be disqualified from participating in the official business of the Board until the charges have been ~~resolved.~~resolved by a determination that the misconduct does not rise to the

level of disciplinary action resulting in the suspension or revocation of the member's professional credential."

SECTION 4. G.S. 90-626(8) reads as rewritten:

"**§ 90-626. Powers and duties.**

The Board shall have the following powers and duties:

...

(8) ~~Establish~~ Pursuant to the maximum amounts set by this Article and other specific authority authorizing fees, establish reasonable fees for applications for examination, certificates of licensure and renewal, and other services provided by the Board.

...."

SECTION 5. G.S. 90-628(b) reads as rewritten:

"(b) The Board may impose the following fees up to the amounts listed below:

(1)	Application for examination	~~$200.00~~$300.00
(1a)	Application packet	25.00
(2)	~~License fee~~Initial license	~~150.00~~300.00
(3)	License renewal	~~100.00~~200.00
(4)	Late renewal penalty	75.00
(5)	License by ~~reciprocity~~endorsement	~~50.00~~300.00
(6)	Duplicate license	25.00
~~(7)~~	~~Provisional license~~	~~150.00.~~"

SECTION 6. G.S. 90-629 reads as rewritten:

"**§ 90-629. Requirements for licensure.**

Upon application to the Board and the payment of the required fees, an applicant may be licensed as a massage and bodywork therapist if the applicant meets all of the following qualifications:

(1) Has obtained a high school diploma or equivalent.

(2) Is 18 years of age or older.

(3) Is of good moral character as determined by the Board.

(4) Has successfully completed a ~~course of study~~training program consisting of a minimum of 500 ~~classroom~~ in-class hours of supervised instruction at a Board-approved school.

(5) Has ~~successfully~~ passed ~~an~~ a competency assessment examination ~~administered by a certifying agency that has been approved by the National Commission of Certifying Agencies (NCCA) and is in good standing with such agency or has successfully passed an examination administered or approved by the Board.~~ that meets generally accepted psychometric principles and standards and is approved by the Board.

(6) Has submitted fingerprint cards in a form acceptable to the Board at the time the license application is filed and consented to a criminal history background check by the North Carolina Department of Justice."

SECTION 7. G.S. 90-630 is repealed.

SECTION 8. Article 36 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"§ 90-630.1. Licensure by endorsement.

(a) The Board may issue a license to a practitioner who is duly licensed, certified, or registered as a massage and bodywork therapist under the laws of another jurisdiction. The practitioner shall be eligible for licensure by endorsement if all of the following qualifications are met:

(1) The applicant meets the requirements of G.S. 90-629(1), (2), (3), and (6), and submits the required application and fees to the Board.

(2) The applicant currently holds a valid license, certificate, or registration as a massage and bodywork therapist in another jurisdiction, and that jurisdiction's requirements for licensure, certification, or registration as a massage and bodywork therapist are substantially equivalent to or exceed the requirements for licensure under this Article.

(3) The applicant is currently a practitioner in good standing, with no disciplinary proceeding or unresolved complaint pending anywhere at the time a license is to be issued in this State.

(4) The applicant passes a jurisprudence examination administered by the Board regarding laws and rules adopted by the Board for licensure under this Article.

(5) The applicant, including applicants credentialed in a foreign country, demonstrates satisfactory proof of proficiency in the English language.

(b) The Board may issue a license by endorsement to a practitioner from another state that does not license, certify, or register massage and bodywork therapists if all of the following qualifications are met:

(1) The applicant meets the requirements of G.S. 90-629(1), (2), (3), and (6), and submits the required application and fees to the Board.

(2) The applicant has passed a psychometrically valid competency assessment examination approved by the Board.

(3) The applicant has graduated from a massage and bodywork therapy school that: (i) offers a curriculum that meets or is substantially equivalent to the standards set forth in the Board's criteria for school approval; and (ii) is licensed or approved by the regulatory authority for schools of massage and bodywork therapy in the state, province, territory, or country in which it operates or is exempt by law.

(4) The applicant is currently a practitioner in good standing, with no disciplinary proceeding or unresolved complaint pending anywhere at the time a license is to be issued in this State.

(5) The applicant passes a jurisprudence examination administered by the Board regarding laws and rules adopted by the Board for licensure under this Article.

(6) The applicant, including an applicant credentialed in a foreign country, demonstrates satisfactory proof of proficiency in the English language.

(7) Notwithstanding the requirements of subdivisions (2) and (3) of this subsection, the applicant has other credentials, to be reviewed by the Board on a case-by-case basis, that are deemed by the Board to be substantially equivalent to the requirements in subdivisions (2) and (3) of this subsection.

(c) The Board shall maintain a list of jurisdictions whose regulatory standards for the practice of massage and bodywork therapy have been determined by the Board to be substantially equivalent to or to exceed the requirements for licensure under this Article."

SECTION 9. 90-631(a) reads as rewritten:

"(a) The Board shall establish rules for the approval of massage and bodywork therapy schools. These rules shall include:

(1) Basic curriculum standards that ensure graduates have the education and skills necessary to carry out the safe and effective practice of massage and bodywork therapy.

(2) Standards for faculty and learning resources.

(3) Requirements for reporting changes in instructional staff and curriculum.

(4) A description of the process used by the Board to approve a school.

Any school that offers a training program in massage and bodywork therapy ~~may~~ not otherwise exempt from the requirements of this Article shall make application for approval to the Board. The Board shall grant approval to ~~schools,~~a school, whether in this State or another state, that ~~meet~~ meets the criteria established by the Board. The Board shall maintain a list of approved schools and a list of community college programs operating pursuant to subsection (b) of this section."

SECTION 10. G.S. 90-632 reads as rewritten:

"**§ 90-632. License renewal and continuing education.**

(a) The license to practice under this Article shall be renewed every two years. ~~When renewing a license, each licensee shall submit to the Board evidence of the successful completion of at least 25 hours of study, as approved by the Board, during the immediately preceding two years, in the practice of massage and bodywork therapy.~~ The initial license renewal is as follows:

(1) If the licensure period is two years or more, each licensee shall submit to the Board evidence of the successful completion of at least 24 hours of study, as approved by the Board, since the initial licensure application date in the practice of massage and bodywork therapy.

(2) If the licensure period is less than two years, but more than one year, each licensee shall submit to the Board evidence of the successful completion of at least 12 hours of study, as approved by the Board, since the initial licensure application date in the practice of massage and bodywork therapy.

(b) For subsequent license renewals, each licensee shall submit to the Board evidence of the successful completion of at least 24 hours of study, as approved by the

Board, since the previous licensure renewal submission date in the practice of massage and bodywork therapy."

SECTION 11. G.S. 90-633 reads as rewritten:

"**§ 90-633. Disciplinary action.**

(a) The Board may deny, suspend, revoke, or refuse to license a massage and bodywork therapist or applicant for any of the following:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

(2) The use of drugs or intoxicating liquors to an extent that affects professional competency.

(3) Conviction of an offense under any municipal, State, or federal narcotic or controlled substance ~~law until proof of rehabilitation can be established.~~law.

(4) Conviction of a felony or other public offense involving moral ~~turpitude until proof of rehabilitation can be established.~~turpitude.

(5) An adjudication of insanity or ~~incompetency until proof of recovery from the condition can be established.~~incompetency.

(6) Engaging in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board, or aiding, abetting, or assisting any other person in the violation of these provisions or rules. For purposes of this subdivision, the phrase 'aiding, abetting, or assisting any other person' does not include acts intended to inform the individual who is not in compliance with this Article of the steps necessary to comply with this Article or any rules adopted by the Board.

(7) The commission of an act of malpractice, gross negligence, or incompetency.

(8) Practice as a licensee under this Article without a valid certificate or renewal.

(9) Engaging in conduct that could result in harm or injury to the public.

(10) The employment of fraud, deceit, or misrepresentation when communicating with the general public, health care professionals, or other business professionals.

(11) Falsely holding out himself or herself as licensed or certified in any discipline of massage and bodywork therapy without successfully completing training approved by the Board in that specialty.

(12) The application of systems of activity by a massage and bodywork therapist during the course of therapy with the intent of providing sexual stimulation or otherwise pursuing sexual contact.

(b) The Board may reinstate a revoked license, revoke censure or other judgment, or remove other licensure restrictions if the Board finds that the reasons for revocation, censure, or other judgment, or other licensure restrictions no longer exist and the massage and bodywork therapist or applicant can reasonably be expected to safely and properly practice as a massage and bodywork therapist."

SECTION 12. G.S. 90-634 reads as rewritten:

"**§ 90-634. Enforcement; injunctive relief.**

(a) It is unlawful for a person not licensed or exempted under this Article to engage in any of the following:

(1) Practice of massage and bodywork therapy.

(2) Advertise, represent, or hold out himself or herself to others to be a massage and bodywork therapist.

(3) Use any title descriptive of any branch of massage and bodywork therapy, as provided in G.S. 90-623, to describe his or her practice.

(b) A person who violates subsection (a) of this section shall be guilty of a Class 1 misdemeanor.

(b1) It is unlawful for an individual, association, partnership, corporation, or other entity to open, operate, or advertise a massage and bodywork therapy school without first having obtained the approval required by G.S. 90-637.1.

(b2) An individual, association, partnership, corporation, or other entity that violates subsection (b1) of this section shall be guilty of a Class 1 misdemeanor.

(c) The Board may make application to superior court for an order enjoining a violation of this Article. Upon a showing by the Board that a ~~person~~ person, association, partnership, corporation, or other entity has violated or is about to violate this Article, the court may grant an injunction, restraining order, or take other appropriate action."

SECTION 13. G.S. 90-634.1 reads as rewritten:

"**§ 90-634.1. 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 continuation of the same act for which the penalty is imposed shall not be the basis for an additional penalty. 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 14. Article 36 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-637. Authority to regulate massage and bodywork therapy schools.**

(a) The Board shall have authority to administer and enforce this Article and to grant and issue approval to massage and bodywork therapy schools whether in this State or another state.

(b) For purposes of this Article, 'massage and bodywork therapy school' means any educational institution that conducts a training program or curriculum for a tuition charge, which is intended to teach adults the knowledge, skills, and abilities necessary for the safe, effective, and ethical practice of massage and bodywork therapy, as defined in this Article.

(c) If a school offers training programs at more than one physical location, each location shall constitute a separate school, as defined in this section.

(d) Notwithstanding G.S. 90-625, regarding the regulation of massage and bodywork therapy schools, the Board shall have the power and duty to:

(1) Formulate criteria and standards for approval of massage and bodywork therapy schools.

(2) Provide for adequate investigations of all schools applying for approval.

(3) Issue approvals to those applicant schools meeting the standards established by the Board.

(4) Maintain a list of schools approved under the provisions of this Article.

(5) Provide for periodic inspection of all schools approved in this State under the provisions of this Article.

(6) Require periodic reports of approved schools.

(e) The Board shall have general supervision over massage and bodywork therapy schools in this State for the purpose of protecting the health, safety, and welfare of the public by having approved schools maintain: (i) adequate, safe, and sanitary facilities; (ii) sufficient and qualified instructional and administrative staff; and (iii) satisfactory programs of operation and instructions; and by having the schools carry out their advertised promises and contracts made with their students and patrons. The Board may adopt rules to approve massage and bodywork therapy schools as authorized under G.S. 90-626(9).

"§ 90-637.1. Massage and bodywork therapy school approval required.

No individual, association, partnership, corporation, or other entity shall open, operate, or advertise a massage and bodywork therapy school in this State unless approval is first secured from the Board and granted in accordance with the provisions of this Article and the rules adopted by the Board.

"§ 90-637.2. Authority to establish fees for massage and bodywork therapy school approval.

(a) The Board shall establish a schedule of reasonable fees for approvals and renewals granted and for inspections performed pursuant to this Article. The fees collected under this section are intended to cover the administrative costs of the approval programs. No fee for application approval or renewal of approval shall be refunded in the event the application is rejected or the approval suspended or revoked.

(b) Fees for Board approval of schools are as follows:

(1)	Request for Application Approval Package	$20.00
(2)	Initial application for approval (one program)	2,000.00
(3)	Initial application for approval of additional programs (same location)	750.00
(4)	Inspection for initial approval or renewal (one program)	1,500.00
(5)	Inspection for initial approval or renewal of additional programs (same location)	500.00
(6)	Renewal of approval (one program)	1,000.00
(7)	Renewal of approval (each additional program)	750.00

(c) A school that is required to have more than one inspection in a fiscal year in order to investigate or verify areas of noncompliance with the standards for school approval shall pay a fee of one thousand five hundred dollars ($1,500) for each additional inspection.

(d) In addition to the inspection fee, schools shall also pay for travel, lodging, and subsistence expenses related to the inspection.

"**§ 90-637.3. Grounds for suspension, revocation, or refusal of massage and bodywork therapy school approval; notice and hearing; judicial review.**

(a) The Board may deny, suspend, revoke, or refuse to approve a massage and bodywork therapy school or program for any of the following:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain approval of a school or program.

(2) Engaging in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board, or aiding, abetting, or assisting any other person in the violation of the provisions of this Article or rules adopted by the Board.

(3) Failure to require its students to complete the minimum standards in order to graduate.

(4) Operating a massage and bodywork therapy school or additional program without approval from this Board.

(5) Engaging in conduct that could result in harm or injury to the public.

(6) The employment of fraud, deceit, or misrepresentation when communicating with the general public, health care professionals, or other business professionals.

(7) Falsely holding out a school or program as approved by this Board.

(8) Failure to allow authorized representatives of the Board to conduct inspections of the school or refusing to make available to the Board, following written notice to the school, the requested information pertaining to the requirements for approval set forth in this Article.

(9) Failure to notify the Board in writing within 30 days of any notification it receives from its accrediting agency or the United States Department of Education Office of Postsecondary Education of a show cause action, probation action, or denial of accreditation.

(10) The applicant for or holder of school approval has pleaded guilty, entered a plea of nolo contendere, or has been found guilty of a crime

involving moral turpitude by a judge or jury in any state or federal court.

(b) A refusal to issue, refusal to renew, or suspension or revocation of school approval under this section shall be made in accordance with Chapter 150B of the General Statutes.

"§ 90-638. Criminal history record checks of applicants for licensure.

(a) All applicants for 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 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, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) The cost of the background check and the fingerprinting shall be borne by the applicant.

(c) If an applicant's criminal history record check reveals one or more convictions of crimes set forth in G.S. 90-622(2a) of this Article, the conviction shall not automatically bar licensure. 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 set forth in G.S. 90-622(2a) of this Article.

If, after reviewing the factors, the Board determines that the grounds set forth in subdivisions (1), (2), (3), (4), (5), or (6) of G.S. 90-637.3(a) exist, the Board may deny 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.

(d) 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 licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 15. Part 2 of Article 4 of Chapter 114 of the General Statutes is amended by adding the following new section to read:

"**§ 114-19.11B. Criminal record checks of applicants for licensure as massage and bodywork therapists.**

The Department of Justice may provide to the North Carolina Board of Massage and Bodywork Therapy from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure pursuant to Article 36 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 16. G.S. 14-202.10 reads as rewritten:

"**§ 14-202.10. Definitions.**

As used in this Article:

(1) "Adult bookstore" means a bookstore:

a. Which receives a majority of its gross income during any calendar month from the sale or rental of publications (including books, magazines, other periodicals, videotapes, compact discs, other photographic, electronic, magnetic, digital, or other imaging medium) which are distinguished or characterized by their emphasis on matter depicting, describing, or relating to specified sexual activities or specified anatomical areas, as defined in this section; or

b. Having as a preponderance (either in terms of the weight and importance of the material or in terms of greater volume of materials) of its publications (including books, magazines, other periodicals, videotapes, compact discs, other photographic, electronic, magnetic, digital, or other imaging medium) which are distinguished or characterized by their emphasis on matter depicting, describing, or relating to specified sexual activities or specified anatomical areas, as defined in this section.

(2) "Adult establishment" means an adult bookstore, adult motion picture theatre, adult mini motion picture theatre, or adult live entertainment ~~business, or massage~~ business as defined in this section.

(3) "Adult live entertainment" means any performance of or involving the actual presence of real people which exhibits specified sexual activities or specified anatomical areas, as defined in this section.

(4) "Adult live entertainment business" means any establishment or business wherein adult live entertainment is shown for observation by patrons.

(5) "Adult motion picture theatre" means an enclosed building or premises used for presenting motion pictures, a preponderance of which are distinguished or characterized by an emphasis on matter depicting, describing, or relating to specified sexual activities or specified anatomical areas, as defined in this section, for observation by patrons therein. "Adult motion picture theatre" does not include any adult mini motion picture theatre as defined in this section.

(6) "Adult mini motion picture theatre" means an enclosed building with viewing booths designed to hold patrons which is used for presenting motion pictures, a preponderance of which are distinguished or characterized by an emphasis on matter depicting, describing or relating to specified sexual activities or specified anatomical areas as defined in this section, for observation by patrons therein.

~~(7) "Massage" means the manipulation of body muscle or tissue by rubbing, stroking, kneading, or tapping, by hand or mechanical device.~~

~~(8) "Massage business" means any establishment or business wherein massage is practiced, including establishments commonly known as health clubs, physical culture studios, massage studios, or massage parlors.~~

(9) "Sexually oriented devices" means without limitation any artificial or simulated specified anatomical area or other device or paraphernalia that is designed principally for specified sexual activities but shall not mean any contraceptive device.

(10) "Specified anatomical areas" means:

a. Less than completely and opaquely covered: (i) human genitals, pubic region, (ii) buttock, or (iii) female breast below a point immediately above the top of the areola; or

b. Human male genitals in a discernibly turgid state, even if completely and opaquely covered.

(11) "Specified sexual activities" means:

a. Human genitals in a state of sexual stimulation or arousal;

b. Acts of human masturbation, sexual intercourse or sodomy; or

c. Fondling or other erotic touchings of human genitals, pubic regions, buttocks or female breasts."

SECTION 17. G.S. 14-202.11(a) reads as rewritten:

"(a) No person shall permit any building, premises, structure, or other facility that contains any adult establishment to contain any other kind of adult establishment. No person shall permit any building, premises, structure, or other facility in which sexually

oriented devices are sold, distributed, exhibited, or contained to contain any adult establishment. No person shall permit the practice of massage and bodywork therapy, as defined in G.S. 90-622, in an adult establishment."

SECTION 18. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1314
PROPOSED COMMITTEE SUBSTITUTE S1314-CSRD-33 [v.6]

6/26/2007 6:41:08 PM

Short Title: Amend Massage & Bodywork Therapy Act. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE LAWS UNDER THE NORTH CAROLINA MASSAGE AND BODYWORK THERAPY PRACTICE ACT TO EXPAND THE EXISTING LAWS REGULATING MASSAGE AND BODYWORK THERAPY SCHOOLS; TO AUTHORIZE THE BOARD TO ESTABLISH FEES FOR LICENSING MASSAGE AND BODYWORK THERAPY SCHOOLS; AND TO ALLOW THE DEPARTMENT OF JUSTICE TO CONDUCT CRIMINAL HISTORY RECORD CHECKS FROM STATE AND NATIONAL REPOSITORIES OF CRIMINAL HISTORY OF APPLICANTS FOR LICENSURE TO PRACTICE MASSAGE AND BODYWORK THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-621 reads as rewritten:

"**§ 90-621. Declaration of purpose.**

~~The General Assembly recognizes that the improper practice of massage and bodywork therapy is potentially harmful to the public. Mandatory licensure of those engaged in the practice of massage and bodywork therapy is necessary to ensure minimum standards of competency and to protect the public health, safety, and welfare.~~The purpose of this Article is to ensure the protection of the health, safety, and welfare of the citizens of this State receiving massage and bodywork therapy services. This purpose is achieved by establishing education and testing standards that ensure competency in the practice of massage and bodywork therapy. Mandatory licensure of those engaged in the practice of massage and bodywork therapy assures the public that each individual has satisfactorily met the standards of the profession and continues to meet both the ethical and competency goals of the profession."

SECTION 2. G.S. 90-622 reads as rewritten:

"**§ 90-622. Definitions.**

The following definitions apply in this Article:

(1) Accreditation. – Status granted to a postsecondary institution of higher learning that has met standards set by an accrediting agency recognized by the Secretary of the United States Department of Education. The accreditation for massage and bodywork schools may be institutional or programmatic in nature.

~~(1)~~(1a) Board. – The North Carolina Board of Massage and Bodywork Therapy.

(2) Board-approved school. – Any massage and bodywork therapy school or training program in this State or another state that is not otherwise exempt from Board approval, that has met the ~~criteria established by the Board.~~standards set forth in this Article, and been granted approval by the Board.

(2a) Criminal history record check. – A report resulting from a request made by the Board to the North Carolina Department of Justice for a history of conviction of a crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice massage and bodywork therapy. The crimes include, but are not limited to, 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.

(2b) Jurisdiction. – The authority, capacity, or right of another state, territory of the United States, District of Columbia, or a foreign country to act.

(3) Massage and bodywork therapy. – Systems of activity applied to the soft tissues of the human body for therapeutic, educational, or relaxation purposes. The application may include:

a. Pressure, friction, stroking, rocking, kneading, percussion, or passive or active stretching within the normal anatomical range of movement.

b. Complementary methods, including the external application of water, heat, cold, lubricants, and other topical preparations.

c. The use of mechanical devices that mimic or enhance actions that may possibly be done by the hands.

(3a) Massage and bodywork therapy school. – Any educational institution that conducts a training program or curriculum for a tuition charge, which is intended to teach adults the knowledge, skills, and abilities necessary for the safe, effective, and ethical practice of massage and bodywork therapy.

(4) Massage and bodywork therapist. – A person licensed under this Article.

(5) Practice of massage and bodywork therapy. – The application of massage and bodywork therapy to any person for a fee or other consideration. ~~"Practice of massage and bodywork therapy" does not include the diagnosis of illness or disease, medical procedures, chiropractic adjustive procedures, electrical stimulation, ultrasound, prescription of medicines, or the use of modalities for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.~~"

SECTION 2.1. G.S. 90-623 is amended by adding a new subsection to read:

"(d) The practice of massage and bodywork therapy shall not include any of the following:

1. The diagnosis of illness or disease.
2. Medical procedures, chiropractic adjustive procedures, electrical stimulation, ultrasound, or prescription of medicines.
3. The use of modalities for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.
4. Sexual activity, which shall mean any direct or indirect physical contact, by any person or between persons, which is intended to erotically stimulate either person, or which is likely to cause such stimulation and includes sexual intercourse, fellatio, cunnilingus, masturbation, or anal intercourse. As used in this subdivision, masturbation means the manipulation of any body tissue with the intent to cause sexual arousal. Sexual activity can involve the use of any device or object and is not dependent on whether penetration, orgasm, or ejaculation has occurred."

SECTION 3. G.S. 90-625 reads as rewritten:

"§ 90-625. North Carolina Board of Massage and Bodywork Therapy.

(a) The North Carolina Board of Massage and Bodywork Therapy is created. The Board shall consist of seven members who are residents of this State and are as follows:

(1) Five members shall be massage and bodywork therapists who have been licensed under this Article and have been in the practice of massage and bodywork therapy for at least five of the last seven years prior to their serving on the Board. ~~The appointments may be made from lists provided by the North Carolina Therapeutic Massage and Bodywork Task Force.~~ Consideration shall be given to geographical distribution, practice setting, clinical specialty, involvement in massage and bodywork therapy education, and other factors that will promote diversity of the profession on the Board. Two of the five members shall be appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, two shall be appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the Governor.

(2) One member shall be a physician licensed pursuant to Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes or a person once licensed as a physician whose license lapsed while the person was in good standing with the profession and eligible for licensure. The appointment shall be made by the Governor and may be made from a list provided by the North Carolina Medical Society.

(3) One member shall be a member of the general public who shall not be licensed under Chapter 90 of the General Statutes or the spouse of a person who is so licensed, or have any financial interest, directly or indirectly, in the profession regulated under this Article. The appointment shall be made by the Governor.

(b) Legislative appointments shall be made in accordance with G.S. 120-121. A vacancy in a legislative appointment shall be filled in accordance with G.S. 120-122.

(c) Each member of the Board shall serve for a term of three years, ending on June 30 of the last year of the term. A member shall not be appointed to serve more than two consecutive terms.

(d) The Board shall elect annually a chair and other officers as it deems necessary. The Board shall meet as often as necessary for the conduct of business but no less than twice a year. The Board shall establish procedures governing the calling, holding, and conducting of regular and special meetings. A majority of the Board shall constitute a quorum.

(e) Each member of the Board may receive per diem and reimbursement for travel and subsistence as set forth in G.S. 93B-5.

(f) Members may be removed by the official who appointed the member for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings as a licensee or other professional credential shall be disqualified from participating in the official business of the Board until the charges

have been ~~resolved.~~resolved by a determination that the misconduct does not rise to the level of disciplinary action resulting in the suspension or revocation of the member's professional credential."

SECTION 3.1. The current terms of the two members of the Board appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate are each extended to a total period of five years, ending on June 30 of the last year of each extended term. Upon the completion of these five year terms, all future members of the Board shall serve three year terms, as provided in G.S. 90-625(c).

SECTION 4. G.S. 90-626(8) reads as rewritten:

"**§ 90-626. Powers and duties.**

The Board shall have the following powers and duties:

...

(8) ~~Establish~~ Pursuant to the maximum amounts set by this Article and other specific authority authorizing fees, establish reasonable fees for applications for examination, certificates of licensure and renewal, approval of massage and body therapy schools, and other services provided by the Board.

...."

SECTION 5. G.S. 90-628(b) reads as rewritten:

"(b) The Board may impose the following fees up to the amounts listed below:

(1)	Application for examination	~~$200.00~~$300.00
(1a)	Application packet	25.00
(2)	~~License fee~~Initial license	~~150.00~~300.00
(3)	License renewal	~~100.00~~200.00
(4)	Late renewal penalty	75.00
(5)	License by ~~reciprocity~~endorsement	~~50.00~~300.00
(6)	Duplicate license	25.00
~~(7)~~	~~Provisional license~~	~~150.00.~~"

SECTION 6. G.S. 90-629 reads as rewritten:

"**§ 90-629. Requirements for licensure.**

Upon application to the Board and the payment of the required fees, an applicant may be licensed as a massage and bodywork therapist if the applicant meets all of the following qualifications:

(1) Has obtained a high school diploma or equivalent.

(2) Is 18 years of age or older.

(3) Is of good moral character as determined by the Board.

(4) Has successfully completed a ~~course of study~~training program consisting of a minimum of 500 ~~classroom~~ in-class hours of supervised instruction at a Board-approved school.

(5) Has ~~successfully~~ passed ~~an~~ a competency assessment examination ~~administered by a certifying agency that has been approved by the National Commission of Certifying Agencies (NCCA) and is in good standing with such agency or has successfully passed an examination~~

~~administered or approved by the Board.~~that meets generally accepted psychometric principles and standards and is approved by the Board.

(6) Has submitted fingerprint cards in a form acceptable to the Board at the time the license application is filed and consented to a criminal history background check by the North Carolina Department of Justice."

SECTION 7. G.S. 90-630 is repealed.

SECTION 8. Article 36 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-630.1. Licensure by endorsement.**

(a) The Board may issue a license to a practitioner who is duly licensed, certified, or registered as a massage and bodywork therapist under the laws of another jurisdiction. The practitioner shall be eligible for licensure by endorsement if all of the following qualifications are met:

(1) The applicant meets the requirements of G.S. 90-629(1), (2), (3), and (6), and submits the required application and fees to the Board.

(2) The applicant currently holds a valid license, certificate, or registration as a massage and bodywork therapist in another jurisdiction, and that jurisdiction's requirements for licensure, certification, or registration as a massage and bodywork therapist are substantially equivalent to or exceed the requirements for licensure under this Article.

(3) The applicant is currently a practitioner in good standing, with no disciplinary proceeding or unresolved complaint pending in any jurisdiction at the time a license is to be issued in this State.

(4) The applicant passes a jurisprudence examination administered by the Board regarding laws and rules adopted by the Board for licensure under this Article.

(5) The applicant, including applicants credentialed in a foreign country, demonstrates satisfactory proof of proficiency in the English language.

(b) The Board may issue a license by endorsement to a practitioner from another state that does not license, certify, or register massage and bodywork therapists if all of the following qualifications are met:

(1) The applicant meets the requirements of G.S. 90-629(1), (2), (3), and (6), and submits the required application and fees to the Board.

(2) The applicant has passed a competency assessment examination that meets generally accepted psychometric principles and standards and is approved by the Board.

(3) The applicant has graduated from a massage and bodywork therapy school that: (i) offers a curriculum that meets or is substantially equivalent to the standards set forth in the Board's criteria for school approval; and (ii) is licensed or approved by the regulatory authority for schools of massage and bodywork therapy in the state, province, territory, or country in which it operates or is exempt by law.

(4) The applicant is currently a practitioner in good standing, with no disciplinary proceeding or unresolved complaint pending in any jurisdiction at the time a license is to be issued in this State.

(5) The applicant passes a jurisprudence examination administered by the Board regarding laws and rules adopted by the Board for licensure under this Article.

(6) The applicant, including an applicant credentialed in a foreign country, demonstrates satisfactory proof of proficiency in the English language.

(7) Notwithstanding the requirements of subdivisions (2) and (3) of this subsection, the applicant has other credentials, to be reviewed by the Board on a case-by-case basis, that are deemed by the Board to be substantially equivalent to the requirements in subdivisions (2) and (3) of this subsection.

(c) The Board shall maintain a list of jurisdictions whose regulatory standards for the practice of massage and bodywork therapy have been determined by the Board to be substantially equivalent to or to exceed the requirements for licensure under this Article."

SECTION 9. 90-631(a) reads as rewritten:

"(a) The Board shall establish rules for the approval of massage and bodywork therapy schools. These rules shall include:

(1) Basic curriculum standards that ensure graduates have the education and skills necessary to carry out the safe and effective practice of massage and bodywork therapy.

(2) Standards for faculty and learning resources.

(3) Requirements for reporting changes in instructional staff and curriculum.

(4) A description of the process used by the Board to approve a school.

Any school that offers a training program in massage and bodywork therapy ~~may~~ not otherwise exempt from the requirements of this Article shall make application for approval to the Board. The Board shall grant approval to ~~schools,~~a school, whether in this State or another state, that ~~meet~~ meets the criteria established by the Board. The Board shall maintain a list of approved schools and a list of community college programs operating pursuant to subsection (b) of this section."

SECTION 10. G.S. 90-632 reads as rewritten:

"**§ 90-632. License renewal and continuing education.**

(a) The license to practice under this Article shall be renewed every two years. ~~When renewing a license, each licensee shall submit to the Board evidence of the successful completion of at least 25 hours of study, as approved by the Board, during the immediately preceding two years, in the practice of massage and bodywork therapy.~~

(b) The continuing education requirement for the initial license renewal is as follows:

(1) If the licensure period is two years or more, each licensee shall submit to the Board evidence of the successful completion of at least 24 hours

of study, as approved by the Board, since the initial licensure application date in the practice of massage and bodywork therapy.

(2) If the licensure period is less than two years, but more than one year, each licensee shall submit to the Board evidence of the successful completion of at least 12 hours of study, as approved by the Board, since the initial licensure application date in the practice of massage and bodywork therapy.

(c) For subsequent license renewals, each licensee shall submit to the Board evidence of the successful completion of at least 24 hours of study, as approved by the Board, since the previous licensure renewal submission date in the practice of massage and bodywork therapy."

SECTION 11. G.S. 90-633 reads as rewritten:

"**§ 90-633. Disciplinary action.**

(a) The Board may deny, suspend, revoke, or refuse to license a massage and bodywork therapist or applicant for any of the following:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

(2) The use of drugs or intoxicating liquors to an extent that affects professional competency.

(3) Conviction of an offense under any municipal, State, or federal narcotic or controlled substance ~~law until proof of rehabilitation can be established.~~law.

(4) Conviction of a felony or other public offense involving moral ~~turpitude until proof of rehabilitation can be established.~~turpitude.

(5) An adjudication of insanity or ~~incompetency until proof of recovery from the condition can be established.~~incompetency.

(6) Engaging in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board, or aiding, abetting, or assisting any other person in the violation of these provisions or rules. For purposes of this subdivision, the phrase 'aiding, abetting, or assisting any other person' does not include acts intended to inform the individual who is not in compliance with this Article of the steps necessary to comply with this Article or any rules adopted by the Board.

(7) The commission of an act of malpractice, gross negligence, or incompetency.

(8) Practice as a licensee under this Article without a valid certificate or renewal.

(9) Engaging in conduct that could result in harm or injury to the public.

(10) The employment of fraud, deceit, or misrepresentation when communicating with the general public, health care professionals, or other business professionals.

(11) Falsely holding out himself or herself as licensed or certified in any discipline of massage and bodywork therapy without successfully completing training approved by the Board in that specialty.

(12) The application of systems of activity by a massage and bodywork therapist during the course of therapy with the intent of providing sexual stimulation or otherwise pursuing sexual contact.

(b) The Board may reinstate a revoked license, revoke censure or other judgment, or remove other licensure restrictions if the Board finds that the reasons for revocation, censure, or other judgment, or other licensure restrictions no longer exist and the massage and bodywork therapist or applicant can reasonably be expected to safely and properly practice as a massage and bodywork therapist."

SECTION 12. G.S. 90-634 reads as rewritten:

"**§ 90-634. Enforcement; injunctive relief.**

(a) It is unlawful for a person not licensed or exempted under this Article to engage in any of the following:

(1) Practice of massage and bodywork therapy.

(2) Advertise, represent, or hold out himself or herself to others to be a massage and bodywork therapist.

(3) Use any title descriptive of any branch of massage and bodywork therapy, as provided in G.S. 90-623, to describe his or her practice.

(b) A person who violates subsection (a) of this section shall be guilty of a Class 1 misdemeanor.

(b1) It is unlawful for an individual, association, partnership, corporation, or other entity to open, operate, or advertise a massage and bodywork therapy school without first having obtained the approval required by G.S. 90-637.1.

(b2) An individual, association, partnership, corporation, or other entity that violates subsection (b1) of this section shall be guilty of a Class 3 misdemeanor.

(c) The Board may make application to superior court for an order enjoining a violation of this Article. Upon a showing by the Board that a ~~person~~ person, association, partnership, corporation, or other entity has violated or is about to violate this Article, the court may grant an injunction, restraining order, or take other appropriate action."

SECTION 13. G.S. 90-634.1 reads as rewritten:

"**§ 90-634.1. 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 continuation of the same act for which the penalty is imposed shall not be the basis for an additional penalty. 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 14. Article 36 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-637. Authority to regulate massage and bodywork therapy schools.**

(a) The Board shall have authority to administer and enforce this Article and to grant and issue approval to massage and bodywork therapy schools whether in this State or another state.

(b) If a massage and bodywork therapy school offers training programs at more than one physical location, each location shall constitute a separate massage and bodywork therapy school.

(d) Notwithstanding G.S. 90-626, regarding the regulation of massage and bodywork therapy schools, the Board shall have the power and duty to:

(1) Formulate criteria and standards for approval of massage and bodywork therapy schools.
(2) Provide for adequate investigations of all massage and bodywork therapy schools applying for approval.
(3) Issue approvals to those applicant massage and bodywork therapy schools meeting the standards established by the Board.
(4) Maintain a list of massage and bodywork therapy schools approved under the provisions of this Article.
(5) Provide for periodic inspection of all massage and bodywork therapy schools approved in this State under the provisions of this Article.
(6) Require periodic reports of approved massage and bodywork therapy schools.

(e) The Board shall have general supervision over massage and bodywork therapy schools in this State for the purpose of protecting the health, safety, and welfare of the public by requiring that approved massage and bodywork therapy schools maintain: (i) adequate, safe, and sanitary facilities; (ii) sufficient and qualified instructional and administrative staff; and (iii) satisfactory programs of operation and instructions; and by requiring that massage and bodywork therapy schools carry out their advertised promises and contracts made with their students and patrons. The Board may adopt rules to approve massage and bodywork therapy schools as authorized under G.S. 90-626(9).

"**§ 90-637.1. Massage and bodywork therapy school approval required.**

No individual, association, partnership, corporation, or other entity shall open, operate, or advertise a massage and bodywork therapy school in this State unless it has first complied with all the requirements of this Article and rules adopted by the Board and has been approved by the Board.

"§ 90-637.2. Authority to establish fees for massage and bodywork therapy school approval.

(a) The Board shall establish a schedule of reasonable fees for approvals and renewals granted and for inspections performed pursuant to this Article. The fees collected under this section are intended to cover the administrative costs of the approval programs. No fee for application approval or renewal of approval shall be refunded in the event the application is rejected or the approval suspended or revoked.

(b) Fees for Board approval of schools are as follows:

(1)	Request for Application Approval Package	$20.00
(2)	Initial application for approval (one program)	2,000.00
(3)	Initial application for approval of additional programs (same location)	750.00
(4)	Inspection for initial approval or renewal (one program)	1,500.00
(5)	Inspection for initial approval or renewal of additional programs (same location)	500.00
(6)	Renewal of approval (one program)	1,000.00
(7)	Renewal of approval (each additional program)	750.00

(c) A school that is required to have more than one inspection in a fiscal year in order to investigate or verify areas of noncompliance with the standards for school approval shall pay a fee of one thousand five hundred dollars ($1,500) for each additional inspection.

(d) In addition to the inspection fee, schools shall also pay for travel, lodging, and subsistence expenses related to the inspection.

"§ 90-637.3. Grounds for suspension, revocation, or refusal of massage and bodywork therapy school approval; notice and hearing; judicial review.

(a) The Board may deny, suspend, revoke, or refuse to approve a massage and bodywork therapy school for any of the following reasons:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain approval of a massage and bodywork therapy school.

(2) Engaging in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board, or aiding, abetting, or assisting any other person in the violation of the provisions of this Article or rules adopted by the Board.

(3) Failure to require that its students must complete the minimum standards in order to graduate.

(4) Operating a massage and bodywork therapy school without approval from this Board.

(5) Engaging in conduct that could result in harm or injury to the public.

(6) The employment of fraud, deceit, or misrepresentation when communicating with the general public, health care professionals, or other business professionals.

(7) Falsely holding out a massage and bodywork therapy school as approved by this Board.

(8) Failure to allow authorized representatives of the Board to conduct inspections of the massage and bodywork therapy school or refusing to make available to the Board, following written notice to the massage and bodywork therapy school, the requested information pertaining to the requirements for approval set forth in this Article.

(9) Failure to notify the Board in writing within 30 days of any notification it receives from its accrediting agency or the United States Department of Education Office of Postsecondary Education of a show cause action, probation action, or denial of accreditation.

(10) The applicant for or holder of massage and bodywork therapy school approval has pleaded guilty, entered a plea of nolo contendere, or has been found guilty of a crime involving moral turpitude by a judge or jury in any state or federal court.

(b) A refusal to issue, refusal to renew, or suspension or revocation of massage and bodywork therapy school approval under this section shall be made in accordance with Chapter 150B of the General Statutes.

"**§ 90-638. Criminal history record checks of applicants for licensure.**

(a) All applicants for 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 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, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) The cost of the background check and the fingerprinting shall be borne by the applicant.

(c) If an applicant's criminal history record check reveals one or more convictions of crimes set forth in G.S. 90-622(2a) of this Article, the conviction shall not automatically bar licensure. 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 set forth in G.S. 90-622(2a) of this Article.

If, after reviewing the factors, the Board determines that any of the grounds set forth in the subdivisions of G.S. 90-633(a) exist, the Board may deny 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.

(d) The Board, its officers, and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 15. Part 2 of Article 4 of Chapter 114 of the General Statutes is amended by adding the following new section to read:

"**§ 114-19.11B. Criminal record checks of applicants for licensure as massage and bodywork therapists.**

The Department of Justice may provide to the North Carolina Board of Massage and Bodywork Therapy from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure pursuant to Article 36 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 16. This act becomes effective October 1, 2007, and applies to the actions of therapists and schools on or after that date, and to massage and bodywork therapist applications for licensure, and massage and bodywork therapy school applications for Board approval submitted to the Board on or after that date.

SENATE BILL 1314:
Amend Massage & Bodywork Therapy Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 26, 2007
Introduced by:	Sen. Cowell	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to First Edition S1314-CSRD-33		

SUMMARY: Senate Bill 1314 makes a number of changes to the Massage and Bodywork Therapy Practice Act (Article 36 of Chapter 90 of the General Statutes). It authorizes the North Carolina Board of Massage and Bodywork Therapy ("Board) to increase its fees, repeals reciprocal licensure in favor of licensure by endorsement, revises the continuing education requirements, authorizes criminal background checks for licensure applicants, and adds a number of new statutes related to the approval and oversight of massage and bodywork therapy schools.

The PCS primarily removes revisions to the criminal law related to adult establishments contained in the 1st Edition. It also includes Session Law intended to put certain positions on the Board back on a staggered, 3 year basis.

The act becomes effective October 1, 2007, and applies to applications for licensure and approval made on or after that date.

CURRENT LAW: Article 36 of Chapter 90 of the General Statutes contains the Massage and Bodywork Therapy Practice Act. Massage and bodywork therapy (massage therapy) is defined as "systems of activity applied to the soft tissues of the human body for therapeutic, educational, or relaxation purposes, including friction, stroking, rocking, kneading, percussion, or stretching within the normal anatomical range of movement.[1] In order to be a licensed massage therapist, a person must be at least 18 years old, have obtained a high school diploma or its equivalent, be of good moral character, successfully complete a course of study, and pass a licensure exam approved by the Board.[2] A person may not hold himself or herself out as a massage therapist unless the person is licensed by the Board.[3] The Board consists of 7 members, 4 appointed by the General Assembly and 3 appointed by the Governor.[4] The Board has rule making authority, the authority to license and discipline licensees, and the authority to approve massage and bodywork therapy schools. The Board may deny, suspend, revoke or refuse to license a massage therapist or applicant for a number of reasons, including fraud, drug or alcohol abuse, conviction of a drug or alcohol related crime, violating the Article, and practicing without a valid license.[5]

BILL ANALYSIS:

Section 1 amends the Declaration of Purpose for the Massage and Bodywork Therapy Act as the protection of the welfare of North Carolinians by establishing licensure standards that ensure competency in the practice.

Section 2 amends the Definitions section of the Article to include the definition of a "criminal background check" and a "massage and bodywork therapy school."

---

[1] G.S. 90-622(3).
[2] G.S. 90-629.
[3] G.S. 90-623.
[4] G.S. 90-625.
[5] G.S. 90-633.

Section 2.1 moves language describing acts that do not constitute massage therapy from the definitions section to a new subsection of G.S. 90-623. It also adds language excluding sexual activity from the practice of massage and bodywork therapy.

Section 3 allows a person whose license as a physician has lapsed while the person was in good standing to serve on the Board. **Section 3.1** extends the term of 2 Board members in order to re-establish staggered terms.

Section 4 authorizes the Board to set fees within the maximum ranges authorized by statue.

Section 5 raises the minimum fees for many of the licensure categories.

Section 6 makes submission of fingerprint cards a requirement for applicants for licensure.

Sections 7 & 8 repeal G.S. 90-630 regarding licensure by reciprocity and replaces it with G.S. 90-630.1 which establishes licensure by endorsement. This procedure will allow persons from states that do not license massage therapists to obtain licensure in North Carolina if certain requirements are met.

Section 9 clarifies that schools that are exempt from the Board's approval process do not have to meet the requirements of the Article. These schools primarily include massage therapy programs offered by the North Carolina Community College system.

Section 10 changes the continuing education requirements from 25 hours every 2 years to 24 hours every 2 years.

Section 11 grants to the Board the authority to suspend or revoke a licensee's license for the application of systems of activity during the course of therapy with the intent of providing sexual stimulation or otherwise pursuing sexual contact. It also allows the Board to reinstate a license if it finds the grounds for the restrictions no longer exist and the therapist can be expected to safely and properly practice massage therapy.

Section 12 makes it a Class 3 misdemeanor for a person to operate a massage therapy school without first being approved by the Board.

Section 13 provides that the continuation of a condition that leads to a monetary penalty does not constitute a separate offense subject to an additional penalty or penalties. It also repeals language that would allow the Board to assess the costs of the disciplinary action against the person found to have violated the Article.

Section 14 enacts 5 new statutes related to the approval and regulation of massage therapy schools. G.S. 90-637 authorizes the Board to establish minimum criteria and standards for schools, provide for adequate investigation, and provide for periodic inspections of the schools. G.S. 90-637.1 provides that no massage therapy school may operate in this state without first obtaining Board approval. G.S. 90-637.2 sets the fees for application, renewal and investigations of schools by the Board. G.S. 90-637.3 establishes the grounds for suspension, revocation, or refusal of licensure by the Board for a massage therapy school. Finally, G.S. 90-638 requires all applicants to submit to a criminal background check. Conviction of a crime will not automatically exclude an applicant from licensure, but the Board must consider the conviction when granting a license.

Section 15 authorizes the North Carolina Department of Justice to conduct a State and national criminal background check on applicants for massage therapy licensure.

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Reynolds (THD) Clodfelter	SOUTHLIGHT, INC. / NCSAPA / COALITION
Adam Searcy	NCJC
Abbie C. Evamidon	NHSS-NC
Jonathan Mabon	MHA-NC
Jack Register	NASW-NC
Ashley Mabe	EGHS
Crissie Curtis	EGHS
Ed Sansbury	AMTA-NC
Ann Christian	Atty.
Peri Morgan	NC100
Fil Modlin	Eastern Band of Cherokee

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emma Thorne	TAX PyE
[illegible]	NMRS
Terry Bradley	NCFB
[illegible]	[illegible]
Patrick Boffeli	NMRS
Daniel Baum	Kennedy Covington
Chris Phillips	DMH/DD/SAS
Bill Rust	[illegible]
[illegible]	R. Ellis & Assoc.
[illegible]	Bode & Assoc.
Tommy Suter	Wyeth

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jill Hinson Keel	Autism Society of NC
Alex Miller	Covenant with NC's Children
[illegible]	NAMI NC
Micah Sickel	UNC Hospital
Sally Cameron	NC Psychological Assoc
Robin Haffner	NC Psychiatric Assoc
[illegible]	NCCCS
Sharon Thompson	NQC
Kim Jernigan	NC Community College System
Jim B. Martin	DPH / TPCB
Pete Jarvis	Gov Office

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Kimbrell	Pfizer Inc
Bruce Thompson	Pfizer Inc
TJ Schmidlin	Carolinas Healthcare
Brad Adcock	BCBSNC
Joe Stewart	IFNC
Matt Farrell	Policy Group
Mary Bode	AARP NC
Kelly Bryant	Rep. Alexander
Jim Jarrett	Rep Glazier/Insight
Jeremy Merrill	Intern - Rep Locke
Holly Beeson	AHA / ASA

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Colleen Kochanek	Smith Moore
[illegible]	Action for Children NC
Roc Saoth	NC CCC
BRIAN LEWIS	Coalition to NC's Children
Jennifer Lanaie	NCAE
Judy McConnell	TOG
Kathryn Lanier	~~DHHS~~
Christopher Morgan	
Carolina Lee	Wake County Human Services
[illegible]	DHHS - DMH/DD/SAS
[illegible]	"

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martin Pharr	DJJDP
[illegible]	DHHS
[illegible]	DHHS
LORI ANN HARRIS	LAHA
[illegible]	NCALA
[illegible]	ENGR
[illegible]	Bono + Assoc
[illegible]	NCATLCF
Joann Stevens	Nursing
JOHN GOODMAN	NC CHAMBER
[illegible]	BCBS

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John East	NCFPC
Jim Long	NCDOT
Rose Williams	NCDOI
Amy McConkey	Smith Anderson
Ashley Hayes	WASTE MGMT
Jamal Jones	NCHA
Chip Bigger	NCMS
John McAlister	NC Chamber
Lee Ann C. Pearson	NCRA
Barbara Conrad	BCBSNC
John Boardick	Astra Zeneca

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
David Kelly	Intern Rep. Insko
[illegible]	CSC
[illegible]	[illegible]
[illegible]	
Bill Johnston	
Deepti Damle	
[illegible]	NC Boards Council
[illegible]	Pazon + Spinelli
Tom Vitaglione	Action for Children

VISITOR REGISTRATION SHEET

Senate Health Care — **June 27, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	DP Assoc
Charles Wilkins	AFLAC
Jordan Schrader	pfizer
Lee Dixon	FRD/NCGA
J Craig Whitt	UHC

Senate Health Care Committee
Wednesday, July 11, 2007, 11:00 AM
Room 544, Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1294	**No Smoking/LTC Facilities.**	**Representative Justice Representative Howard**
SB 1314	**Amend Massage & Bodywork Therapy Act.**	**Senator Cowell**
HB 818	**Amend Practice of Medicine Laws.-AB**	**Representative Allen**
HB 1400	**Tissue Bank Referrals/Funeral Directors.**	**Representative Faison Representative Holloway**
SB 864	**Amend Practice of Medicine Laws.-AB**	**Senator Purcell**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, July 11, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 11, 2007, in Room 544 of the Legislative Office Building, with fourteen members present, and Senator William R. Purcell presiding. Senator Purcell welcomed the committee members present, and introduced the pages and sergeants-at-arms. He recognized physicians from Greenville, Wake County, and the Doctor of the Day.

Senator Purcell recognized Representative Julia Howard to present HB1294, *No Smoking/LTC Facilities*. Senator Foriest moved to adopt a proposed committee substitute. Senator Brunstetter asked how practical it would be to ask the elderly to go outside to smoke. Rep. Howard replied that most facilities have a sheltered area where they can go to smoke and that the facilities industry and the tobacco industry have signed off on this bill. Senator Forrester pointed out that this does not affect smokeless or chewing tobacco. Senator Blake moved for a favorable report as to the PCS, unfavorable as to the original bill.

Senator Cowell brought SB1314, *Amend Massage & Bodywork Therapy Act* before the Committee. Senator Allran asked as to the official, legal, title of persons performing this work. The president of the North Carolina Massage Therapy Association responded that it is "licensed massage therapist". Senators Jones and Malone asked about criminal convictions in regard to licensure, and Ms. Kory Goldsmith said that there are restrictions about this contained in the bill. Senator Forrester asked if health insurance pays for massage therapy, and the answer was yes, under some circumstances spelled out by the insurance company. Senator Foriest moved for a favorable report as to the PCS, unfavorable as to the original bill, and the bill was referred to the Finance Committee.

A committee substitute for HB1400, *Tissue Bank Referrals/Funeral Directors* was brought to the Committee by Representative Holloway. He said that there was no known opposition to this bill and that all parties concerned were in agreement with it. Senator Brunstetter moved for a favorable report as to the committee substitute.

Senator Purcell presented a proposed committee substitute for SB864, *Amend Practice of Medicine Laws.-AB.* After some discussion, Senator Berger moved for a favorable report as to the proposed committee substitute. The bill was re-referred to the Finance Committee.

The meeting adjourned at 11:47 A.M.

Senator William R. Purcell, Co-Chair

Senator Stan Bingham, Co-Chair

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 11, 2007

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

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

S.B. **1314** Amend Massage & Bodywork Therapy Act.

Draft Number:	35409
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **1294** No Smoking/LTC Facilities.

Draft Number:	70582
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **1400** Tissue Bank Referrals/Funeral Directors.

Draft Number:	60381
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, July 11, 2007

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

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

S.B. **864** Amend Practice of Medicine Laws.-AB

Draft Number:	15116
Sequential Referral:	
Recommended Referral:	Finance
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1294

Committee Substitute Favorable 4/26/07

Committee Substitute #2 Favorable 5/10/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1294-PCS70582-SQ-51

Short Title: No Smoking/LTC Facilities. (Public)

Sponsors:

Referred to:

April 4, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING INSIDE LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.4 reads as rewritten:

"**§ 131D-4.4. Adult care home minimum safety ~~requirements.~~requirements; smoking prohibited inside long-term care facilities; penalty.**

(a) In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

(b) Smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No

Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (c) of this section. A violation of subsection (c) of this section constitutes a civil offense only and is not a crime."

SECTION 2. Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.**

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section. A violation of subsection (b) of this section constitutes a civil offense only and is not a crime."

SECTION 3. Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-6. Smoking prohibited; penalty.**

(a) Smoking is prohibited inside facilities licensed under this Chapter and inside State psychiatric hospitals. As used in this section, 'smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, 'inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of subsection (b) of this section constitutes a civil offense only and is not a crime."

SECTION 4. Part 3 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-143. Smoking prohibited; penalty.**

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

(1) 'Employee' includes an individual under contract with the home care agency to provide home care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section. A violation of subsection (a) of this section constitutes a civil offense only and is not a crime."

SECTION 5. This act becomes effective October 1, 2007, and applies to violations committed on or after that date. G.S. 131D-4.4(c)(3), 131E-114.3(b)(3), and 122C-6(b)(3), as enacted by this act, apply to individuals admitted to the facility on or after October 1, 2007.

HOUSE BILL 1294:
No Smoking/LTC Facilities

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 10, 2007
Introduced by:	Reps. Howard, Justice	**Summary by:**	Shawn Parker
Version:	PCS to Third Edition H1294-CSSQ-51		Legislative Analyst

SUMMARY: House Bill 1294 would prohibit smoking inside defined long-term care facilities and would allow the Department of Health and Human Services to impose a penalty of up to $200 per violation on the owner, manager or operator who fails to comply with the law.

The Proposed Committee Substitute would insert language to clarify the fact that violations of the provisions of the act would be civil offenses only and not crimes. The PCS also would establish an effective date of October 1, 2007 rather than the previous 'when it becomes law'.

BILL ANALYSIS: House Bill 1294 would prohibit smoking inside long-term care facilities, including adult care homes, nursing homes, skilled nursing facilities, State psychiatric hospitals, and other licensed facilities that provide long-term care services as defined in the bill. Smoking is defined as the "use or possession of any lighted cigar, cigarette, pipe or other lighted tobacco product."

The owner, manager, or operator of a long-term care facility shall do the following:

(1) conspicuously post a sign stating that smoking is prohibited;

(2) direct any person smoking inside the facility to extinguish any lighted tobacco product; and

(3) provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

The Department of Health and Human Services (Department) would be authorized to impose an administrative penalty of up to $200 per violation on the owner, manager, or operator of the facility not complying with the above provisions.

Home care agencies would prohibit their employees from smoking while providing services in an individual's home. The home care agency would be directed to inform its clients about the prohibition. The Department would be authorized to impose an administrative penalty of up to $200 per violation on the owner, manager, or operator of the home care agency who fails to comply.

EFFECTIVE DATE: The act would become effective October 1, 2007 and would apply to violations committed on or after that date. Notice requirements under the bill apply to individuals admitted to the facility on or after October 1, 2007.

This summary was substantially contributed to by Tim Hovis, Counsel to House Judiciary I.

H1294e3-SMSQ-CSSQ-51

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 1294

Committee Substitute Favorable 4/26/07

Committee Substitute #2 Favorable 5/10/07

Short Title: No Smoking/LTC Facilities. (Public)

Sponsors:

Referred to:

April 4, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING INSIDE LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.4 reads as rewritten:

"**§ 131D-4.4. Adult care home minimum safety ~~requirements.~~requirements; smoking prohibited inside long-term care facilities; penalty.**

(a) In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

(b) Smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (c) of this section."

SECTION 2. Part 1 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.**

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, State psychiatric hospitals, and other licensed facilities that provide long-term care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(3) 'Inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section."

SECTION 3. Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-6. Smoking prohibited; penalty.**

(a) Smoking is prohibited inside facilities licensed under this Chapter and inside State psychiatric hospitals. As used in this section, 'smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, 'inside' means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section."

SECTION 4. Part 3 of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-143. Smoking prohibited; penalty.**

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

(1) 'Employee' includes an individual under contract with the home care agency to provide home care services.

(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section."

SECTION 5. This act is effective when it becomes law and applies to violations committed on and after that date. G.S. 131D-4.4(c)(3), 131E-114.3(b)(3), and 122C-6(b)(3), as enacted by this act, apply to individuals admitted to the facility on and after the effective date of this act.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1314
PROPOSED COMMITTEE SUBSTITUTE S1314-PCS35409-RDf-33

Short Title: Amend Massage & Bodywork Therapy Act. (Public)

Sponsors:

Referred to:

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE LAWS UNDER THE NORTH CAROLINA MASSAGE AND BODYWORK THERAPY PRACTICE ACT TO EXPAND THE EXISTING LAWS REGULATING MASSAGE AND BODYWORK THERAPY SCHOOLS; TO AUTHORIZE THE BOARD TO ESTABLISH FEES FOR LICENSING MASSAGE AND BODYWORK THERAPY SCHOOLS; AND TO ALLOW THE DEPARTMENT OF JUSTICE TO CONDUCT CRIMINAL HISTORY RECORD CHECKS FROM STATE AND NATIONAL REPOSITORIES OF CRIMINAL HISTORY OF APPLICANTS FOR LICENSURE TO PRACTICE MASSAGE AND BODYWORK THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-621 reads as rewritten:

"**§ 90-621. Declaration of purpose.**

~~The General Assembly recognizes that the improper practice of massage and bodywork therapy is potentially harmful to the public. Mandatory licensure of those engaged in the practice of massage and bodywork therapy is necessary to ensure minimum standards of competency and to protect the public health, safety, and welfare.~~The purpose of this Article is to ensure the protection of the health, safety, and welfare of the citizens of this State receiving massage and bodywork therapy services. This purpose is achieved by establishing education and testing standards that ensure competency in the practice of massage and bodywork therapy. Mandatory licensure of those engaged in the practice of massage and bodywork therapy assures the public that each individual has satisfactorily met the standards of the profession and continues to meet both the ethical and competency goals of the profession."

SECTION 2. G.S. 90-622 reads as rewritten:

"**§ 90-622. Definitions.**

The following definitions apply in this Article:

(1) Accreditation. – Status granted to a postsecondary institution of higher learning that has met standards set by an accrediting agency recognized by the Secretary of the United States Department of Education. The accreditation for massage and bodywork schools may be institutional or programmatic in nature.

~~(1)~~(1a) Board. – The North Carolina Board of Massage and Bodywork Therapy.

(2) Board-approved school. – Any massage and bodywork therapy school or training program in this State or another state that is not otherwise exempt from Board approval, that has met the ~~criteria established by the Board.~~standards set forth in this Article, and been granted approval by the Board.

(2a) Criminal history record check. – A report resulting from a request made by the Board to the North Carolina Department of Justice for a history of conviction of a crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice massage and bodywork therapy. The crimes include, but are not limited to, 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.

(2b) Jurisdiction. – The authority, capacity, or right of another state, territory of the United States, District of Columbia, or a foreign country to act.

(3) Massage and bodywork therapy. – Systems of activity applied to the soft tissues of the human body for therapeutic, educational, or relaxation purposes. The application may include:

a. Pressure, friction, stroking, rocking, kneading, percussion, or passive or active stretching within the normal anatomical range of movement.

b. Complementary methods, including the external application of water, heat, cold, lubricants, and other topical preparations.

c. The use of mechanical devices that mimic or enhance actions that may possibly be done by the hands.

(3a) Massage and bodywork therapy school. – Any educational institution that conducts a training program or curriculum for a tuition charge, which is intended to teach adults the knowledge, skills, and abilities necessary for the safe, effective, and ethical practice of massage and bodywork therapy.

(4) Massage and bodywork therapist. – A person licensed under this Article.

(5) Practice of massage and bodywork therapy. – The application of massage and bodywork therapy to any person for a fee or other consideration. ~~"Practice of massage and bodywork therapy" does not include the diagnosis of illness or disease, medical procedures, chiropractic adjustive procedures, electrical stimulation, ultrasound, prescription of medicines, or the use of modalities for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.~~"

SECTION 2.1. G.S. 90-623 is amended by adding a new subsection to read:

"(d) The practice of massage and bodywork therapy shall not include any of the following:

(1) The diagnosis of illness or disease.

(2) Medical procedures, chiropractic adjustive procedures, electrical stimulation, ultrasound, or prescription of medicines.

(3) The use of modalities for which a license to practice medicine, chiropractic, nursing, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.

(4) Sexual activity, which shall mean any direct or indirect physical contact, by any person or between persons, which is intended to erotically stimulate either person, or which is likely to cause such stimulation and includes sexual intercourse, fellatio, cunnilingus, masturbation, or anal intercourse. As used in this subdivision, masturbation means the manipulation of any body tissue with the intent to cause sexual arousal. Sexual activity can involve the use of any device or object and is not dependent on whether penetration, orgasm, or ejaculation has occurred."

SECTION 3. G.S. 90-625 reads as rewritten:

"§ 90-625. North Carolina Board of Massage and Bodywork Therapy.

(a) The North Carolina Board of Massage and Bodywork Therapy is created. The Board shall consist of seven members who are residents of this State and are as follows:

(1) Five members shall be massage and bodywork therapists who have been licensed under this Article and have been in the practice of massage and bodywork therapy for at least five of the last seven years prior to their serving on the Board. ~~The appointments may be made from lists provided by the North Carolina Therapeutic Massage and Bodywork Task Force.~~ Consideration shall be given to geographical distribution, practice setting, clinical specialty, involvement in massage and bodywork therapy education, and other factors that will promote diversity of the profession on the Board. Two of the five members shall be appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, two shall be appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the Governor.

(2) One member shall be a physician licensed pursuant to Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes or a person once licensed as a physician whose license lapsed while the person was in good standing with the profession and eligible for licensure. The appointment shall be made by the Governor and may be made from a list provided by the North Carolina Medical Society.

(3) One member shall be a member of the general public who shall not be licensed under Chapter 90 of the General Statutes or the spouse of a person who is so licensed, or have any financial interest, directly or indirectly, in the profession regulated under this Article. The appointment shall be made by the Governor.

(b) Legislative appointments shall be made in accordance with G.S. 120-121. A vacancy in a legislative appointment shall be filled in accordance with G.S. 120-122.

(c) Each member of the Board shall serve for a term of three years, ending on June 30 of the last year of the term. A member shall not be appointed to serve more than two consecutive terms.

(d) The Board shall elect annually a chair and other officers as it deems necessary. The Board shall meet as often as necessary for the conduct of business but no less than twice a year. The Board shall establish procedures governing the calling, holding, and conducting of regular and special meetings. A majority of the Board shall constitute a quorum.

(e) Each member of the Board may receive per diem and reimbursement for travel and subsistence as set forth in G.S. 93B-5.

(f) Members may be removed by the official who appointed the member for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings as a licensee or other professional credential shall be disqualified from participating in the official business of the Board until the charges

have been ~~resolved.~~resolved by a determination that the misconduct does not rise to the level of disciplinary action resulting in the suspension or revocation of the member's professional credential."

SECTION 3.1. The current terms of the two members of the Board appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate are each extended to a total period of five years, ending on June 30 of the last year of each extended term. Upon the completion of these five year terms, all future members of the Board shall serve three year terms, as provided in G.S. 90-625(c).

SECTION 4. G.S. 90-626(8) reads as rewritten:

"**§ 90-626. Powers and duties.**

The Board shall have the following powers and duties:

...

(8) ~~Establish~~ Pursuant to the maximum amounts set by this Article and other specific authority authorizing fees, establish reasonable fees for applications for examination, certificates of licensure and renewal, approval of massage and bodywork therapy schools, and other services provided by the Board.

...."

SECTION 5. G.S. 90-628(b) reads as rewritten:

"(b) The Board may impose the following fees up to the amounts listed below:

(1)	Application for examination	~~$200.00~~$300.00
(1a)	Application packet	25.00
(2)	~~License fee~~Initial license	~~150.00~~300.00
(3)	License renewal	~~100.00~~200.00
(4)	Late renewal penalty	75.00
(5)	License by ~~reciprocity~~endorsement	~~50.00~~300.00
(6)	Duplicate license	~~25.00~~25.00.
~~(7)~~	~~Provisional license~~	~~150.00.~~"

SECTION 6. G.S. 90-629 reads as rewritten:

"**§ 90-629. Requirements for licensure.**

Upon application to the Board and the payment of the required fees, an applicant may be licensed as a massage and bodywork therapist if the applicant meets all of the following qualifications:

(1) Has obtained a high school diploma or equivalent.

(2) Is 18 years of age or older.

(3) Is of good moral character as determined by the Board.

(4) Has successfully completed a ~~course of study~~training program consisting of a minimum of 500 ~~classroom~~ in-class hours of supervised instruction at a Board-approved school.

(5) Has ~~successfully~~ passed ~~an~~ a competency assessment examination ~~administered by a certifying agency that has been approved by the National Commission of Certifying Agencies (NCCA) and is in good standing with such agency or has successfully passed an examination~~

~~administered or approved by the Board.~~that meets generally accepted psychometric principles and standards and is approved by the Board.

(6) Has submitted fingerprint cards in a form acceptable to the Board at the time the license application is filed and consented to a criminal history background check by the North Carolina Department of Justice."

SECTION 7. G.S. 90-630 is repealed.

SECTION 8. Article 36 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"§ 90-630.1. Licensure by endorsement.

(a) The Board may issue a license to a practitioner who is duly licensed, certified, or registered as a massage and bodywork therapist under the laws of another jurisdiction. The practitioner shall be eligible for licensure by endorsement if all of the following qualifications are met:

(1) The applicant meets the requirements of G.S. 90-629(1), (2), (3), and (6) and submits the required application and fees to the Board.

(2) The applicant currently holds a valid license, certificate, or registration as a massage and bodywork therapist in another jurisdiction, and that jurisdiction's requirements for licensure, certification, or registration as a massage and bodywork therapist are substantially equivalent to or exceed the requirements for licensure under this Article.

(3) The applicant is currently a practitioner in good standing, with no disciplinary proceeding or unresolved complaint pending in any jurisdiction at the time a license is to be issued in this State.

(4) The applicant passes a jurisprudence examination administered by the Board regarding laws and rules adopted by the Board for licensure under this Article.

(5) The applicant, including applicants credentialed in a foreign country, demonstrates satisfactory proof of proficiency in the English language.

(b) The Board may issue a license by endorsement to a practitioner from another state that does not license, certify, or register massage and bodywork therapists if all of the following qualifications are met:

(1) The applicant meets the requirements of G.S. 90-629(1), (2), (3), and (6) and submits the required application and fees to the Board.

(2) The applicant has passed a competency assessment examination that meets generally accepted psychometric principles and standards and is approved by the Board.

(3) The applicant has graduated from a massage and bodywork therapy school that: (i) offers a curriculum that meets or is substantially equivalent to the standards set forth in the Board's criteria for school approval; and (ii) is licensed or approved by the regulatory authority for schools of massage and bodywork therapy in the state, province, territory, or country in which it operates or is exempt by law.

(4) The applicant is currently a practitioner in good standing, with no disciplinary proceeding or unresolved complaint pending in any jurisdiction at the time a license is to be issued in this State.

(5) The applicant passes a jurisprudence examination administered by the Board regarding laws and rules adopted by the Board for licensure under this Article.

(6) The applicant, including an applicant credentialed in a foreign country, demonstrates satisfactory proof of proficiency in the English language.

(7) Notwithstanding the requirements of subdivisions (2) and (3) of this subsection, the applicant has other credentials, to be reviewed by the Board on a case-by-case basis, that are deemed by the Board to be substantially equivalent to the requirements in subdivisions (2) and (3) of this subsection.

(c) The Board shall maintain a list of jurisdictions whose regulatory standards for the practice of massage and bodywork therapy have been determined by the Board to be substantially equivalent to or to exceed the requirements for licensure under this Article."

SECTION 9. G.S. 90-631(a) reads as rewritten:

"(a) The Board shall establish rules for the approval of massage and bodywork therapy schools. These rules shall include:

(1) Basic curriculum standards that ensure graduates have the education and skills necessary to carry out the safe and effective practice of massage and bodywork therapy.

(2) Standards for faculty and learning resources.

(3) Requirements for reporting changes in instructional staff and curriculum.

(4) A description of the process used by the Board to approve a school.

Any school that offers a training program in massage and bodywork therapy ~~may~~ not otherwise exempt from the requirements of this Article shall make application for approval to the Board. The Board shall grant approval to ~~schools,~~a school, whether in this State or another state, that ~~meet~~ meets the criteria established by the Board. The Board shall maintain a list of approved schools and a list of community college programs operating pursuant to subsection (b) of this section."

SECTION 10. G.S. 90-632 reads as rewritten:

"**§ 90-632. License renewal and continuing education.**

(a) The license to practice under this Article shall be renewed every two years. ~~When renewing a license, each licensee shall submit to the Board evidence of the successful completion of at least 25 hours of study, as approved by the Board, during the immediately preceding two years, in the practice of massage and bodywork therapy.~~

(b) The continuing education requirement for the initial license renewal is as follows:

(1) If the licensure period is two years or more, each licensee shall submit to the Board evidence of the successful completion of at least 24 hours

of study, as approved by the Board, since the initial licensure application date in the practice of massage and bodywork therapy.

(2) If the licensure period is less than two years, but more than one year, each licensee shall submit to the Board evidence of the successful completion of at least 12 hours of study, as approved by the Board, since the initial licensure application date in the practice of massage and bodywork therapy.

(c) For subsequent license renewals, each licensee shall submit to the Board evidence of the successful completion of at least 24 hours of study, as approved by the Board, since the previous licensure renewal submission date in the practice of massage and bodywork therapy."

SECTION 11. G.S. 90-633 reads as rewritten:

"**§ 90-633. Disciplinary action.**

(a) The Board may deny, suspend, revoke, or refuse to license a massage and bodywork therapist or applicant for any of the following:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

(2) The use of drugs or intoxicating liquors to an extent that affects professional competency.

(3) Conviction of an offense under any municipal, State, or federal narcotic or controlled substance ~~law until proof of rehabilitation can be established.~~law.

(4) Conviction of a felony or other public offense involving moral ~~turpitude until proof of rehabilitation can be established.~~turpitude.

(5) An adjudication of insanity or ~~incompetency until proof of recovery from the condition can be established.~~incompetency.

(6) Engaging in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board, or aiding, abetting, or assisting any other person in the violation of these provisions or rules. For purposes of this subdivision, the phrase 'aiding, abetting, or assisting any other person' does not include acts intended to inform the individual who is not in compliance with this Article of the steps necessary to comply with this Article or any rules adopted by the Board.

(7) The commission of an act of malpractice, gross negligence, or incompetency.

(8) Practice as a licensee under this Article without a valid certificate or renewal.

(9) Engaging in conduct that could result in harm or injury to the public.

(10) The employment of fraud, deceit, or misrepresentation when communicating with the general public, health care professionals, or other business professionals.

(11) Falsely holding out himself or herself as licensed or certified in any discipline of massage and bodywork therapy without successfully completing training approved by the Board in that specialty.

(12) The application of systems of activity by a massage and bodywork therapist during the course of therapy with the intent of providing sexual stimulation or otherwise pursuing sexual contact.

(b) The Board may reinstate a revoked license, revoke censure or other judgment, or remove other licensure restrictions if the Board finds that the reasons for revocation, censure, or other judgment or other licensure restrictions no longer exist and the massage and bodywork therapist or applicant can reasonably be expected to safely and properly practice as a massage and bodywork therapist."

SECTION 12. G.S. 90-634 reads as rewritten:

"**§ 90-634. Enforcement; injunctive relief.**

(a) It is unlawful for a person not licensed or exempted under this Article to engage in any of the following:

(1) Practice of massage and bodywork therapy.

(2) Advertise, represent, or hold out himself or herself to others to be a massage and bodywork therapist.

(3) Use any title descriptive of any branch of massage and bodywork therapy, as provided in G.S. 90-623, to describe his or her practice.

(b) A person who violates subsection (a) of this section shall be guilty of a Class 1 misdemeanor.

(b1) It is unlawful for an individual, association, partnership, corporation, or other entity to open, operate, or advertise a massage and bodywork therapy school without first having obtained the approval required by G.S. 90-637.1.

(b2) An individual, association, partnership, corporation, or other entity that violates subsection (b1) of this section shall be guilty of a Class 3 misdemeanor.

(c) The Board may make application to superior court for an order enjoining a violation of this Article. Upon a showing by the Board that a ~~person~~ person, association, partnership, corporation, or other entity has violated or is about to violate this Article, the court may grant an injunction, restraining order, or take other appropriate action."

SECTION 13. G.S. 90-634.1 reads as rewritten:

"**§ 90-634.1. 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 continuation of the same act for which the penalty is imposed shall not be the basis for an additional penalty. 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 14. Article 36 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"§ 90-637. Authority to regulate massage and bodywork therapy schools.

(a) The Board shall have authority to administer and enforce this Article and to grant and issue approval to massage and bodywork therapy schools whether in this State or another state.

(b) If a massage and bodywork therapy school offers training programs at more than one physical location, each location shall constitute a separate massage and bodywork therapy school.

(c) Notwithstanding G.S. 90-626, regarding the regulation of massage and bodywork therapy schools, the Board shall have the power and duty to:

(1) Formulate criteria and standards for approval of massage and bodywork therapy schools.
(2) Provide for adequate investigations of all massage and bodywork therapy schools applying for approval.
(3) Issue approvals to those applicant massage and bodywork therapy schools meeting the standards established by the Board.
(4) Maintain a list of massage and bodywork therapy schools approved under the provisions of this Article.
(5) Provide for periodic inspection of all massage and bodywork therapy schools approved in this State under the provisions of this Article.
(6) Require periodic reports of approved massage and bodywork therapy schools.

(d) The Board shall have general supervision over massage and bodywork therapy schools in this State for the purpose of protecting the health, safety, and welfare of the public by requiring that approved massage and bodywork therapy schools maintain: (i) adequate, safe, and sanitary facilities; (ii) sufficient and qualified instructional and administrative staff; and (iii) satisfactory programs of operation and instructions; and by requiring that massage and bodywork therapy schools carry out their advertised promises and contracts made with their students and patrons. The Board may adopt rules to approve massage and bodywork therapy schools as authorized under G.S. 90-626(9).

"§ 90-637.1. Massage and bodywork therapy school approval required.

No individual, association, partnership, corporation, or other entity shall open, operate, or advertise a massage and bodywork therapy school in this State unless it has first complied with all the requirements of this Article and rules adopted by the Board and has been approved by the Board.

"§ 90-637.2. Authority to establish fees for massage and bodywork therapy school approval.

(a) The Board shall establish a schedule of reasonable fees for approvals and renewals granted and for inspections performed pursuant to this Article. The fees collected under this section are intended to cover the administrative costs of the approval programs. No fee for application approval or renewal of approval shall be refunded in the event the application is rejected or the approval suspended or revoked.

(b) Fees for Board approval of schools are as follows:

(1)	Request for Application Approval Package	$20.00
(2)	Initial application for approval (one program)	2,000.00
(3)	Initial application for approval of additional programs (same location)	750.00
(4)	Inspection for initial approval or renewal (one program)	1,500.00
(5)	Inspection for initial approval or renewal of additional programs (same location)	500.00
(6)	Renewal of approval (one program)	1,000.00
(7)	Renewal of approval (each additional program)	750.00

(c) A school that is required to have more than one inspection in a fiscal year in order to investigate or verify areas of noncompliance with the standards for school approval shall pay a fee of one thousand five hundred dollars ($1,500) for each additional inspection.

"§ 90-637.3. Grounds for suspension, revocation, or refusal of massage and bodywork therapy school approval; notice and hearing; judicial review.

(a) The Board may deny, suspend, revoke, or refuse to approve a massage and bodywork therapy school for any of the following reasons:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain approval of a massage and bodywork therapy school.

(2) Engaging in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board, or aiding, abetting, or assisting any other person in the violation of the provisions of this Article or rules adopted by the Board.

(3) Failure to require that its students must complete the minimum standards in order to graduate.

(4) Operating a massage and bodywork therapy school without approval from this Board.

(5) Engaging in conduct that could result in harm or injury to the public.

(6) The employment of fraud, deceit, or misrepresentation when communicating with the general public, health care professionals, or other business professionals.

(7) Falsely holding out a massage and bodywork therapy school as approved by this Board.

(8) Failure to allow authorized representatives of the Board to conduct inspections of the massage and bodywork therapy school or refusing to

make available to the Board, following written notice to the massage and bodywork therapy school, the requested information pertaining to the requirements for approval set forth in this Article.

(9) Failure to notify the Board in writing within 30 days of any notification it receives from its accrediting agency or the United States Department of Education Office of Postsecondary Education of a show cause action, probation action, or denial of accreditation.

(10) The applicant for or holder of massage and bodywork therapy school approval has pleaded guilty, entered a plea of nolo contendere, or has been found guilty of a crime involving moral turpitude by a judge or jury in any state or federal court.

(b) A refusal to issue, refusal to renew, or suspension or revocation of massage and bodywork therapy school approval under this section shall be made in accordance with Chapter 150B of the General Statutes.

"§ 90-638. Criminal history record checks of applicants for licensure.

(a) All applicants for 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 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, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(b) The cost of the background check and the fingerprinting shall be borne by the applicant.

(c) If an applicant's criminal history record check reveals one or more convictions of crimes set forth in G.S. 90-622(2a) of this Article, the conviction shall not automatically bar licensure. 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 set forth in G.S. 90-622(2a) of this Article.

If, after reviewing the factors, the Board determines that any of the grounds set forth in the subdivisions of G.S. 90-633(a) exist, the Board may deny 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.

(d) The Board, its officers, and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 15. Part 2 of Article 4 of Chapter 114 of the General Statutes is amended by adding the following new section to read:

"**§ 114-19.11B. Criminal record checks of applicants for licensure as massage and bodywork therapists.**

The Department of Justice may provide to the North Carolina Board of Massage and Bodywork Therapy from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure pursuant to Article 36 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 16. This act becomes effective October 1, 2007, and applies to the actions of therapists and schools on or after that date and to massage and bodywork therapist applications for licensure, and massage and bodywork therapy school applications for Board approval submitted to the Board on or after that date.

SENATE BILL 1314:
Amend Massage & Bodywork Therapy Act

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 10, 2007
Introduced by:	Sen. Cowell	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition S1314-CSRCf-33[v.9]		Committee Counsel

SUMMARY: ***Senate Bill 1314 amends the laws under the North Carolina Massage and Bodywork Therapy Practice Act to expand the authority of the Massage and Bodywork Therapy Board to regulate massage and bodywork therapy schools; to authorize the Board to establish fees for licensing massage and bodywork therapy schools; and to allow the North Carolina Department of Justice to conduct criminal history record checks from state and national repositories of criminal history of applicants for licensure to practice massage and bodywork therapy.***

The Proposed Committee substitute removes language in the 1st Edition that would have amended the criminal laws related to adult establishments. It also reduces the punishment to a Class 3 misdemeanor for operating a massage and bodywork therapy school without approval by the Board.

CURRENT LAW: Article 36 of Chapter 90 of the General Statutes contains the Massage and Bodywork Therapy Practice Act. It establishes the legal requirement for the licensure and regulation of practitioners. The Article also creates a 7 member licensing Board charged with rule-making authority. Effective July 1, 2006, the Board has authority to adopt rules for approving massage and bodywork therapy schools. Massage and bodywork therapy programs operated by accredited degree or diploma granting colleges or universities are exempt from the Board's approval and licensure process. This exemption expressly applies to programs offered by the Community College System and the constituent institutions of The University of North Carolina.

BILL ANALYSIS:

Section 1 revises G.S. 90-621 regarding the purpose of the Article.

Section 2 amends G.S. 90-622, the definitions to add the term "accreditation", "criminal history record check", and "massage and bodywork therapy school".

Section 2.1 amends G.S. 90-623 by adding a subsection that outlines certain practices that do not constitute the practice of massage and bodywork therapy. Most of this language is just moved from the definitions section, but the new language also goes into some detail to explain that sexual activity intended to erotically stimulate either the therapist or the client does not constitute the practice of massage and bodywork therapy.

Section 3 amends G.S. 90-625 regarding appointments to the Board. The change allows a physician with a lapsed license to serve on the Board if the license lapsed while the person was in good standing with the profession and eligible for licensure.

Section 3.1 enacts uncodified language to extend the terms of two members of the Board appointed by the General Assembly to five year terms. Apparently, the existing staggering of Board members has become confused and this language is intended to bring the appointment process back to the original staggering of terms.

Sections 4 and 5 amend G.S. 90-626 regarding the powers and duties of the Board. The changes allow the Board to adopt fees for the approval of massage and bodywork therapy schools, subject to the maximum amounts set out by statutes.

Section 6 amends G.S. 90-629 regarding the requirements that an applicant must meet in order to be licensed by the Board. The changes allow the Board to use competency assessment examination that meet generally accepted psychometric principles and standards, and requires the applicant to submit fingerprints and submit to a criminal background check.

Section 7 repeals G.S. 90-630 which allows the Board to license out of state therapists who meet certain criteria.

Section 8 creates a new statute that allows the Board to issue licensure by endorsement. This process applies both to states that have similar licensure standards and to states that do not have a licensure process, provided other qualifications are met.

Section 9 amends G.S. 90-631 to make it clear that a massage and bodywork therapy school that is not otherwise exempt from the Board's approval authority must apply to the Board for approval.

Section 10 amends G.S. 90-632 to specify the continuing education requirements for initial licensure renewal and different ones for subsequent licensure renewals.

Section 11 amends G.S. 90-633 regarding the Board's authority to refuse to issue, suspend, or revoke a license. These include conviction of a controlled substance offense, conviction of a crime of moral turpitude, and an adjudication of incompetency. It also adds language authorizing the Board to refuse to issue, suspend or revoke a license if the therapist uses the application of systems of activity with the intent of providing sexual stimulation or otherwise pursing sexual contact.

Section 12 amends G.S. 90-634 to make it a Class 3 misdemeanor to operate a massage and bodywork therapy school without first being approved by the Board.

Section 13 amends G.S. 90-634.1 to provide that continued violation of the Article or rules adopted by the Board shall not be the basis for an additional penalty.

Section 14 enacts G.S. 90-637 and G.S. 90-637.1 which specifies the Board's authority to administer and enforce the Article with regard to the approval of massage and bodywork therapy schools. The Board may formulate criteria and standards for approval, investigate all schools applying for approval, issue approvals and provide periodic inspections of the schools. It also enacts G.S. 90-637.2 which sets the maximum fees the Board may charge in the regulation and approval of schools, G.S. 90-637.3 sets out grounds for the Board suspending, revoking, or refusing to issue an approval of a school. Finally, the Section enacts G.S. 90-638 requiring all applicants for licensure to consent to a criminal background check.

Section 15 amends Chapter 114 of the General Statutes to authorize the Department of Justice to provide the Board with the criminal history of any applicant for licensure.

EFFECTIVE DATE: This act becomes effective October 1, 2007, and applies to the actions of therapists and schools on or after that date, and to massage and bodywork therapist applications for licensure, and massage and bodywork therapy school applications for Board approval submitted to the Board on or after that date.

S1314e1-SMRC-CSRCf-33v9

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1400

Committee Substitute Favorable 5/4/07

Committee Substitute #2 Favorable 5/22/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H1400-PCS60381-SQ-50

Short Title: Tissue Bank Referrals/Funeral Directors. (Public)

Sponsors:

Referred to:

April 12, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE TAKING OR RECOVERY OF HUMAN TISSUE AT A FUNERAL ESTABLISHMENT BY ANY PERSON, WITH CERTAIN EXCEPTIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-210.25 is amended by adding the following new subsection to read:

"(e1) The taking or recovery of human tissue at a funeral establishment by any person is prohibited. The prohibition does not apply to any of the following:

(1) A licensee under this Article that performs embalming or otherwise prepares a dead human body in the ordinary course of business.

(2) The Chief Medical Examiner or anyone acting under the Chief Medical Examiner's authority.

(3) An autopsy technician who takes or recovers tissue from a dead human body if all of the following apply:

a. The taking or recovery is the subject of an academic research program.

b. The academic research program has appropriate Institutional Review Board supervision.

c. The academic research program has obtained informed consent of the donor or the person legally authorized to provide consent.

No funeral establishment or person licensed under this Article shall permit the taking or recovery of human tissue from a dead human body in its custody or control for human transplantation purposes or for research purposes, except that a funeral establishment or person licensed under this Article may permit an autopsy technician to take or recover tissue at a funeral establishment pursuant to subdivision (3) of this

subsection. No funeral establishment or any of its licensees, agents, or employees shall accept, solicit, or offer to accept any payment, gratuity, commission, or compensation of any kind for referring potential tissue donors to a tissue bank or tissue broker or to an eye bank or eye broker. For purposes of this subsection, the term "tissue" does not include an eye."

SECTION 2. This act is effective when it becomes law and applies to deaths occurring on or after that date.

HOUSE BILL 1400:
Tissue Bank Referrals/Funeral Directors

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 6, 2007
Introduced by:	Reps. Holloway, Faison	**Summary by:**	Shawn Parker
Version:	PCS to Third Edition H1400-CSSQ-50		Legislative Analyst

SUMMARY: ***House Bill 1400 would prohibit funeral establishments and persons licensed under Article 13A of Chapter 90 of the General Statutes (Practice of Funeral Service) from permitting the taking or recovery of human tissue from a dead human body in its custody or control for human transplantation purposes or for research purposes.***

The Senate Proposed Committee Substitute allows funeral establishments to permit tissue removal for certain academic research programs.

BILL ANALYSIS: House Bill 1400 would amend the Funeral Service licensing law to prohibit the taking or recovery of human tissue at a funeral establishment by any person, except by:

- A licensee that performs embalming or otherwise prepares a dead human body in the ordinary course of business.
- The Chief Medical Examiner or some acting under the Examiner's authority.
- An autopsy technician procuring tissue subject to an academic research program that has obtained consent and is operating under the supervision of Institutional Review Board.

The bill would prohibit funeral establishments and persons licensed under Article 13A of Chapter 90 of the General Statutes (Practice of Funeral Service) from permitting the taking or recovery of human tissue from a dead human body in its custody or control for human transplantation purposes or for research purposes. It would also prohibit licensees from accepting or soliciting payment for referring potential tissue donors to a tissue bank or broker.

For the purposes of this act the term "tissue" does not include an eye.

CURRENT LAW: The Uniform Anatomical Gift Act, set out in Chapter 130A of the General Statutes (Article 16, Part 3), makes it possible for anyone to donate organs and/or tissue by completing a Uniform Donor Card. If a person dies and has not made a gift, then the decedent's spouse, an adult child, either parent, an adult sibling, or other persons as listed by priority in the law are authorized to donate all or any part of a decedent's body for education, research, or transplantation.. If the gift is of a part of the body, the donee or other person authorized to accept the gift may employ or authorize any surgeon or physician to carry out the appropriate procedures for removing or transplanting that part of the body. An exception exists with respect to eyes, which may be removed by "a qualified individual" as specified in the law, including an embalmer licensed to practice in this State. The donee is required to have the part removed within 24 hours of the decedent's death, without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the surviving spouse, next-of-kin or other persons under obligation to dispose of the body.

The practice of Funeral Service is regulated by Article 13A of Chapter 90 of the General Statutes, and the requirements for licensing are set out in G.S. 90-210.25. The practice of funeral services includes

"engaging in the care or disposition of dead human bodies or in the practice of disinfecting and preparing by embalming or otherwise dead human bodies for the funeral service, transportation, burial or cremation, or in the practice of funeral directing or embalming". The Board of Funeral Service can suspend, revoke, or fail to issue or renew the license of a person or establishment that violates the licensing provisions.

EFFECTIVE DATE: The bill would be effective when it becomes law and apply to deaths occurring on or after that date.

Brenda Carter, counsel to House Judiciary III, substantially contributed to this summary.

H1400e3-SMSQ-CSSQ-50

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 1400

Committee Substitute Favorable 5/4/07

Committee Substitute #2 Favorable 5/22/07

Short Title: Tissue Bank Referrals/Funeral Directors. (Public)

Sponsors:

Referred to:

April 12, 2007

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE TAKING OR RECOVERY OF HUMAN TISSUE AT A FUNERAL ESTABLISHMENT BY ANY PERSON, WITH CERTAIN EXCEPTIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-210.25 is amended by adding the following new subsection to read:

"(e1) The taking or recovery of human tissue at a funeral establishment by any person is prohibited, except that this prohibition does not apply to:

(1) A licensee under this Article that performs embalming or otherwise prepares a dead human body in the ordinary course of business, and

(2) The Chief Medical Examiner or anyone acting under the Chief Medical Examiner's authority.

No funeral establishment or person licensed under this Article shall permit the taking or recovery of human tissue from a dead human body in its custody or control for human transplantation purposes or for research purposes. No funeral establishment or any of its licensees, agents, or employees shall accept, solicit, or offer to accept any payment, gratuity, commission, or compensation of any kind for referring potential tissue donors to a tissue bank or tissue broker or to an eye bank or eye broker. For purposes of this subsection, the term "tissue" does not include an eye."

SECTION 2. This act is effective when it becomes law and applies to deaths occurring on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 864*
PROPOSED COMMITTEE SUBSTITUTE S864-PCS15116-SQf-49

Short Title: Amend Chiropractic Practice Act. (Public)

Sponsors:

Referred to:

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CHIROPRACTIC PRACTICE ACT TO REQUIRE CRIMINAL RECORD CHECKS ON APPLICANTS FOR LICENSURE AS CHIROPRACTIC PHYSICIANS, TO PROHIBIT CHIROPRACTORS FROM OFFERING ENTICEMENTS TO PROSPECTIVE PATIENTS, AND TO EXPAND THE GROUNDS FOR PROFESSIONAL DISCIPLINE OF CHIROPRACTORS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-143.3. Criminal record checks of applicants for licensure.**

(a) Any person applying for licensure as a chiropractic physician in this State shall provide to the Board a fingerprint card in a format acceptable to the Board and a form signed by the applicant consenting to a criminal record check and the use of the applicant's fingerprints and such other identifying information as may be required by the State or national data banks. The Board shall submit these documents to the Department of Justice, along with a request for a criminal record check of the applicant.

(b) Upon receipt of the Board's submission, the Department of Justice shall commence the requested criminal record check. The Department of Justice shall forward a set of the applicant's fingerprints to the State Bureau of Investigation for a search of the State's criminal records, and the State Bureau of Investigation shall forward a set of the applicant's fingerprints to the Federal Bureau of Investigation for a search of national criminal records. The Department of Justice may charge the licensure applicant a fee for performing the criminal record check.

(c) The Board shall keep all information obtained from criminal record checks privileged and confidential, in accordance with applicable State law and federal guidelines, and the information shall not be a public record under Chapter 132 of the General Statutes. If the Board refuses to issue a license based in whole or part on information obtained from a criminal record check, the Board may disclose the relevant

information to the applicant but shall not provide a copy of the record check to the applicant.

(d) When acting in good faith and in conformity with this section, the Board, its officers, and employees shall be immune from civil liability for initially refusing licensure based on information contained in a criminal record check supplied by the Department of Justice, even if the information relied upon is later shown to be erroneous."

SECTION 2. Article 8 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-154.4. Enticements prohibited.**

(a) For purposes of this section, an enticement is anything of monetary value offered by a chiropractor to a prospective patient as an incentive to enter treatment. Except as permitted in subsection (b) of this section, it shall be an unlawful rebate, in violation of G.S. 90-154(b)(12), for a chiropractor to offer an enticement to a prospective patient if, at the time the offer is made, the chiropractor knows or has reason to believe that the prospective patient's treatment expenses will be paid in whole or part by an insurer or other third-party payor.

(b) Unless prohibited by other State or federal law, the following marketing practices shall not be construed as violations of subsection (a) of this section:

(1) Free or reduced rates, services, examinations, or treatments advertised and delivered in conformity with G.S. 90-154.1.

(2) Cash or point-of-service discounts not more than 30 percentage points lower than the charges customarily billed to third-party payors.

(3) Prepaid wellness plans covering only services that can be performed entirely by the offering chiropractor or the chiropractor's staff within the confines of the chiropractor's office.

(4) Merchandise with a value of not more than ten ($10.00) dollars given to a prospective patient for promotional purposes."

SECTION 3. G.S. 90-154(b) is amended by adding a new subdivision to read:

"(b) Any one of the following is grounds for disciplinary action by the Board under subsection (a):

...

(21) Committing an act which demonstrates a lack of good moral character which would have been a basis for denying a license under G.S. 90-143(b)(1), had it been committed before application for a license."

SECTION 4. The Joint Legislative Administrative Procedure Oversight Committee shall undertake a study of the disciplinary authority of all occupational licensing boards subject to Chapter 93B. The Committee shall review the grounds for imposing disciplinary action, the levels of discipline, and the process for making disciplinary determinations used by each of the occupational licensing boards. The Committee may report its findings and any legislative recommendations to the 2008 Regular Session of the General Assembly.

SECTION 5. This act becomes effective October 1, 2007.

SENATE BILL 864:
Amend Chiropractic Practice Act.

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 10, 2007
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S864-CSSQ-49		Legislative Analyst

SUMMARY: The Proposed Committee Substitute requires criminal record checks on applicants for licensure as a chiropractic physician. The bill prohibits chiropractors from offering enticements to perspective patients, and expands the grounds for professional discipline of licensees by the State Board of Chiropractic Examiners (Board). The bill further directs the Joint Legislative Administrative Procedure Oversight Committee to study the disciplinary authority of all occupational licensing boards.

[The PCS is a complete rewriting of SB 864 which as introduced, was identical to H818- Amend Practice of Medicine Laws, which is currently in Senate Health Care Committee]

BILL ANALYSIS:

Section 1 requires a criminal record check of any applicant for licensure as a chiropractic physician. Applicants shall provide to the Board a signed consent form authorizing the background check, a finger print card, and other identifying materials needed to conduct the check. The bill directs the Board to submit these documents to the Department of Justice to commence the criminal record check and authorizes the Department to charge a fee to the applicant for performing the criminal record check.

The section directs the Board to keep all information obtained from the criminal record check confidential and releases the Board from civil liability for refusing to grant a license based on information contained in the criminal record check.

Section 2 prohibits a chiropractor from offering an enticement (anything of monetary value) to a prospective patient, if at the time of the offer the chiropractor knows or has reason to know that an insurer or another third party payor will be paying for some portion of the treatment. The following marketing practices are not violations:

- Free or reduced rates, services, examinations, or treatments advertised and delivered in conformity with G.S. 90-154.1.
- Cash or point of service discounts not more than 30% lower than charges customarily billed to third-party payors.
- Prepaid wellness plans covering services performed entirely within the confines of the chiropractor's office.
- Merchandise not more than $10 in value given to a prospective patient for promotional purposes.

Section 3 provides that a licensee's act demonstrating a lack of good moral character is grounds for disciplinary action by the Board.

Section 4 directs the Joint Legislative Administrative Procedure Oversight Committee to study the disciplinary authority of all occupational licensing boards subject to Chapter 93B.

EFFECTIVE DATE: This act becomes effective October 1, 2007.

S0864e1-SMSQ-CSSQ-49

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 864*

Short Title:	Amend Practice of Medicine Laws.-AB	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 19, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

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

"**§ 90-1A. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Medical Board.

(2) Hearing officer. – Any current or past member of the Board who is a physician, physician assistant, or nurse practitioner and has an active license or approval to practice medical acts, tasks, or functions issued by the Board, or any current or retired judge of the Office of Administrative Hearings, a State district court, a State superior court, the North Carolina Court of Appeals, the North Carolina Supreme Court, or of the federal judiciary who has an active license to practice law in North Carolina and who is a member in good standing of the North Carolina State Bar.

(3) Integrative medicine. – A diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

(4) License. – An authorization issued by the Board to a physician or physician assistant to practice medical acts, tasks, or functions.

(5) The practice of medicine or surgery. – The practice of medicine or surgery includes any of the following acts:

a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State.

b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual.

c. Offering or undertaking to prevent or diagnose, correct, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition.

d. Offering or undertaking to perform any surgical operation on any individual.

e. Rendering a determination of medical necessity or a decision affecting the diagnosis or treatment of a patient.

f. Using the designation 'Doctor,' 'Doctor of Medicine,' 'Doctor of Osteopathy,' 'Doctor of Osteopathic Medicine,' 'Physician,' 'Surgeon,' 'Physician and Surgeon,' 'Dr.,' 'M.D.,' 'D.O.,' or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of another branch of the healing arts for which the individual holds a valid license in this State.

g. Cosmetic procedures employing lasers or other means that involve the revision, destruction, incision, or structural alteration of human tissue, unless otherwise permitted by law.

h. Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient in this State by a physician located outside this State as a result of transmission of individual patient data by electronic or other means from within a state to the physician or the physician's agent.

i. The performance of any act described in this subdivision by use of any electronic means, including the Internet or a toll-free telephone number."

SECTION 2. G.S. 90-2.1 is repealed.

SECTION 3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.1. Powers and duties of the Board.**

(a) The Board 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 and enforce the provisions of this Article.

(4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.

(5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or non-licensee, and, in the case of the death of a licensee, provide for the disposition of the medical records by the estate of the licensee.

(6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.

(7) Develop educational programs to facilitate licensee awareness of provisions contained in this Article and public awareness of the role and function of the Board.

(8) Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care.

(9) Develop and implement methods to assess and improve physician practice.

(10) Develop and implement methods to ensure the ongoing competence of licensees.

(b) Nothing in subsection (a) of this section shall restrict or otherwise limit powers and duties conferred on the Board in other sections of this Article."

SECTION 4. G.S. 90-6(a) is recodified as G.S. 90-8.1; G.S. 90-6(b) and (c), respectively, are recodified as G.S. 90-8.2(a) and (b), respectively; G.S. 90-12.1 is recodified as G.S. 90-12.4; G.S. 90-12.2 is recodified as G.S. 90-12.5; G.S. 90-15 is recodified as G.S. 90-13.1; and G.S. 90-15.1 is recodified as G.S. 90-13.2.

SECTION 5. G.S. 90-8.1, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-8.1. Rules governing applicants for ~~license, examinations, etc.; appointment of subcommittees.~~licensure.**

~~(a)~~ The North Carolina Medical Board is empowered to ~~prescribe such~~adopt rules ~~as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.~~that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures."

SECTION 6. G.S. 90-8.2, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-8.2. Appointment of subcommittees.**

(a) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). ~~The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00).~~ Rules developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and shall become effective

when adopted by both the North Carolina Medical Board and the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these rules.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina Board of Pharmacy to develop rules to govern the performance of medical acts by clinical pharmacist practitioners, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules recommended by the subcommittee shall be adopted in accordance with Chapter 150B of the General Statutes by both the North Carolina Medical Board and the North Carolina Board of Pharmacy and shall not become effective until adopted by both Boards. The North Carolina Medical Board shall have responsibility for ensuring compliance with these rules."

SECTION 7. G.S. 90-9 and G.S. 90-10 are repealed.

SECTION 8. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-9.1. Requirements for licensure as a physician.**

(a) Except as provided in G.S. 90-9.2, to be eligible for licensure as a physician, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has passed each part of an examination described in G.S. 90-10.1;

(2) Is a graduate of:

a. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association and has successfully completed one year of training in a medical education program approved by the Board after graduation from medical school; or

b. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency program approved by the Board before completion of medical school; and

(3) Is of good moral character.

(b) No license may be granted to any applicant who graduated from a medical or osteopathic college that has been disapproved by the Board pursuant to rules adopted by the Board.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.2. Requirements for graduates of foreign medical schools.**

(a) To be eligible for licensure under this section, an applicant who is a graduate of a medical school not approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or the American Osteopathic Association shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed three years of training in a medical education program approved by the Board after graduation from medical school;

(2) Is of good moral character;

(3) Has a currently valid standard cerficate of Educational Commission for Foreign Medical Graduates (ECFMG); and

(4) Is able to communicate in English.

(b) The Board may waive ECFMG certification if the applicant:

(1) Has passed the ECFMG examination and successfully completed an approved Fifth Pathway Program. The applicant is required to provide the original ECFMG Certification Status Report from the ECFMG; or

(2) Has been licensed in another state on the basis of written examination before the establishment of ECFMG in 1958.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.3. Requirements for licensure as a physician assistant.**

(a) To be eligible for licensure as a physician assistant, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by the Committee's predecessor or successor entities;

(2) Holds or previously held a certificate issued by the National Commission on Certification of Physician Assistants; and

(3) Is of good moral character.

(b) Before initiating practice of medical acts, tasks, or functions as a physician assistant, the physician assistant shall provide the Board the name, address, and telephone number of the physician who will supervise the physician assistant in the relevant medical setting.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate. The Board may set fees for physician assistants pursuant to rules adopted by the Board.

"**§ 90-10.1. Examinations accepted by the Board.**

The Board may administer or accept the following examinations for licensure:

(1) A State Board licensing examination.

(2) The National Board of Medical Examiners (NBME) examination or its successor.

(3) The United States Medical Licensing Examination (USMLE)of this section or its successor.

(4) The Federation Licensing Examination (FLEX) or its successor.

(5) Other examinations the Board deems equivalent to the examinations described in subdivisions (1) through (3) of this section pursuant to rules adopted by the Board."

SECTION 9. G.S. 90-11 reads as rewritten:

"**§ 90-11. ~~Qualifications of applicant for license.~~Criminal background checks.**

~~(a) Every applicant for a license to practice medicine or to perform medical acts, tasks, and functions as a physician 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 any such license is granted by the Board to the applicant.~~

~~(b)~~ The Department of Justice may provide a criminal record check to the Board for a person who has applied for a 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 10. G.S. 90-12 and G.S. 90-13 are repealed.

SECTION 11. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-12A. Limited license to practice in a medical education and training program.**

(a) As provided in rules adopted by the Board, the Board may issue a limited license known as a 'resident's training license' to a physician not otherwise licensed by the Board who is participating in a graduate medical education training program.

(b) A resident's training license shall become inactive at the time its holder ceases to be a resident in a training program or obtains any other license to practice medicine issued by the Board. The Board shall retain jurisdiction over the holder of the inactive license.

"**§ 90-12.1A. Limited volunteer license.**

(a) The Board may issue a 'military limited volunteer license' to an applicant who:

(1) Has a license to practice medicine and surgery in another state;

(2) Produces a letter from the state of licensure indicating the applicant is in good standing; and

(3) Is authorized to treat personnel enlisted in a branch of the United States armed services or veterans.

(b) The Board may issue a 'retired limited volunteer license' to an applicant who is a retired physician and has allowed his or her license to practice medicine and surgery in this State or another state to become inactive.

(c) A physician holding a limited license under this section shall comply with the continuing medical education requirements pursuant to rules adopted by the Board.

(d) The Board shall issue a limited license under this section within 30 days after an applicant provides the Board with information satisfying the requirements of this section.

(e) The holder of a limited license under this section may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients. The holder of the limited license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

(f) The holder of a limited license issued pursuant to this section who practices medicine or surgery at places other than clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

(g) The Board may, by rule, require an applicant for a limited license under this section to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-12.2A. Special purpose license.**

(a) The Board may issue a special purpose license to practice medicine to an applicant who:

(1) Holds a full and unrestricted license to practice in at least one other jurisdiction; and

(2) Does not have any current or pending disciplinary or other action against him or her by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the special purpose license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the special purpose license.

"**§ 90-12.3. Medical school faculty license.**

(a) The Board may issue a medical school faculty license to practice medicine and surgery to a physician who:

(1) Holds a full-time appointment as either a lecturer, assistant professor, associate professor, or full professor at one of the following medical schools:

a. Duke University School of Medicine;
b. The University of North Carolina at Chapel Hill School of Medicine;
c. Wake Forest University School of Medicine; or
d. East Carolina University School of Medicine; and

(2) Is not subject to disciplinary order or other action by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the medical school faculty license issued under this section shall not practice medicine or surgery outside the confines of the medical school or an affiliate of the medical school. The holder of the medical school faculty license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the medical school faculty license.

(c) The Board may adopt rules and set fees related to issuing medical school faculty licenses. The Board may, by rule, set a time limit for the term of a medical school facility license."

SECTION 12. G.S. 90-13.1, as recodified in Section 4 of this act, reads as rewritten:

"§ 90-13.1. License ~~fee; salaries, fees, and expenses of Board.~~fees.

(a) Each applicant for a license to practice medicine and surgery in this State under either G.S. ~~90-9, 90-10, or 90-13~~90-9.1, 90-9.2, or 90-9.3 shall pay to the North Carolina Medical Board an application fee of three hundred fifty dollars ($350.00).

(b) ~~Whenever~~ Each applicant for a limited license ~~is granted as provided in~~to practice in a medical education and training program under G.S. ~~90-12, the applicant~~90-12A shall pay to the Board a fee ~~not to exceed~~of 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 one hundred dollars ~~($100.00), and~~($100.00).

(c) ~~where~~ An applicant for a limited volunteer license ~~to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients is granted, the applicant~~under G.S. 90-12.1A shall not pay a fee.

(d) A fee of twenty-five dollars ($25.00) shall be paid for the issuance of a duplicate license.

(e) 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.~~"

SECTION 13. G.S. 90-13.2, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-13.2. Registration every year with Board.**

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday.

(b) A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay ~~a~~ an annual registration fee of one hundred seventy-five dollars ($175.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ($125.00) and those who have a limited volunteer license shall pay an annual registration fee of twenty-five dollars ($25.00). However, licensees who have a limited license to practice for the purpose of education and training under G.S. 90-21A shall not be required to pay more than one annual registration fee for each year of training.

(c) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.

(d) For purposes of annual registration, the Board shall use a simplified registration form which allows registrants to confirm information on file with the Board.

(e) A physician who fails to register as required by this section shall pay an additional fee of fifty dollars ($50.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is automatically inactive. The Board shall retain jurisdiction over the holder of the inactive license.

(f) Except as provided in G.S. ~~90-12(d),~~90-12.1A, a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee.

(g) Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. ~~90-13.~~90-13.1."

SECTION 14. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-13.3. Salaries, fees, expenses of the Board.**

(a) 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.

(b) 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 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."

SECTION 15. G.S. 90-14(11) 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:

...

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for ~~patients.~~patients or failing to maintain acceptable standards of one or more areas of professional physician practice. 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, 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.

...."

SECTION 16. G.S. 90-14.5 reads as rewritten:

"§ 90-14.5. Use of hearing committee and ~~depositions.~~depositions; appointment of hearing officers.

(a) The Board, in its discretion, may designate in writing three or more ~~of its members~~hearing officers 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.

(d) Hearing officers are entitled to receive compensation and reimbursement as authorized by this Article."

SECTION 17. G.S. 90-14.6(b) reads as rewritten:

"(b) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, in proceedings held pursuant to this Article, the ~~licensee~~ individual under investigation may call witnesses, including medical practitioners licensed in the United ~~States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony.~~States with training and experience in the same field of practice as the individual under investigation and familiar with the standard of care among members of the same health care profession in North Carolina. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties."

SECTION 18. 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.**

(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.~~license.

(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 by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, complaint or, disciplinary 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 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.~~Board and transcripts of any deposition taken by Board

counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.

(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~~ may report the information to the appropriate law enforcement ~~agency.~~agency or district attorney of the district in which the offense was committed.

(i) The Board shall cooperate with and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the investigating ~~agency.~~agency or district attorney. Information disclosed by the Board to an investigative agency or district attorney 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 or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities 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 19. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; ~~practicing defined;~~ penalties.**

(a) No person shall perform any act constituting the practice of medicine or surgery, as defined in this Article, 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, 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.

~~(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.~~

(c) The following shall not constitute practicing medicine or surgery as defined in ~~subsection (b) of this section:~~this Article:

(1) The administration of domestic or family ~~remedies in cases of emergency.~~remedies.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and rules developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of chiropody by any legally licensed chiropodist when engaged in the practice of chiropody, and without the use of any drug.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(11a) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery so long as:

a. The physician or surgeon has an oral or written agreement with a sports team to provide general or emergency medical care to the team members, coaching staff, or families traveling with the team for a specific sporting event taking place in this State; and

b. The physician or surgeon does not provide care or consultation to any person residing in this State other than an individual described in sub-subdivision a. of this subdivision.

The exemption shall remain in force while the physician or surgeon is traveling with the team. The exemption shall not exceed 10 days per individual sporting event. However, the executive director of the Board may grant a physician or surgeon additional time for exemption of up to 20 additional days per individual sporting event.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State.

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.

b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.

c. The physician receives no compensation for the services.

d. The physician provides those services within this State for no more than 30 days per calendar year.

e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

SECTION 20. G.S. 90-18.1(a) reads as rewritten:

"(a) Any person who is licensed under the provisions of G.S. ~~90-11~~90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician may use the title "physician assistant". Any other person who uses the title in any form or holds out to be a physician assistant or to be so licensed, shall be deemed to be in violation of this Article."

SECTION 21. G.S. 90-18.1 is amended by adding the following new subsections to read:

"(g) Any person who is licensed under G.S. 90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician shall comply with each of the following:

(1) Maintain a current and active license to practice in this State.

(2) Maintain an active registration with the Board.

(3) Have a current Intent to Practice form filed with the Board.

(h) A physician assistant serving active duty in the United States military is exempt from the requirements of subdivision 9 (g)(3) of this section.

(i) A physician assistant's license shall become inactive any time the holder fails to comply with the requirements of subsection (g) of this section. A physician assistant with an inactive license shall not practice medical acts, tasks, or functions. The Board shall retain jurisdiction over the holder of the inactive license."

SECTION 22. G.S. 90-21 is repealed.

SECTION 23. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Senate Health Care — **July 11, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thurston Webb	Smith Anderson
Jon Chichwak	Wake Med
Tommy Suter	Wyeth
Keith Reschly MD	Doctor of the Day / Reschly Family Med PA Southport, NC
Bonnie Kennedy	Raleigh NC Board of Massage & Bodywork
Tom Vitagliano	Action for Children
Bill Wilson	AARP
[illegible]	BCA
[illegible]	ACNS
Janet Jones	NCHA
[illegible]	MWC

VISITOR REGISTRATION SHEET

Senate Health Care — **July 11, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCOA
Vance Kallam	N.C. Board of Chiropractic Ex.
Fred Jordan	North Carolina Eye Bank
Jim D. Martin	NC DPH / TPCB
John Thuss	Caldwell County Comm.
Mac Boxley	NC Foot & Ankle Soc.
Paige Ollaske	Gov's Office
Rose Williams	DOI
Christine Wunsche	10&- Daily Bulletin
Christie Crump	WakeMed
Dana Simpson	SIA

VISITOR REGISTRATION SHEET

Committee on Education/Public Instruction — July 11, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	Jordan Price Law Firm
Ann Lucas	DMH
David Kolbaugh	NC Board of Nursing
Tim Beitel MD	NC medical Society
Greg Cannon MD	NC Med Society
Cathy Wright	NCMS
Allison Clipp	NCMS
Mary Ross	Carolina Justice Policy Center
Charmaine Fuller	CJPC
[illegible]	JD, AL, PA
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

Committee on Education/Public Instruction — July 11, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Sansbury	AMTA-NC
Ann Christian	Atty.
David Barnes	Poyner + Spruill
Joyce Peters	JP Assoc
Elizabeth Self	NCCCS
Judith Mann	NCCCS
Sharon Thompson	JCC
David Sullivan	NCCCS
Daniel Isaacs	Kennedy Covington
Barbara Conklin	BSCOA
John Bowden	Astra Zeneca

VISITOR REGISTRATION SHEET

Committee on Education/Public Instruction — July 11, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	CAA
DEBBY SEYMORE	Craven County Schools

VISITOR REGISTRATION SHEET

Senate Health Care — **July 11, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Price	BCA

Senate Health Care Committee
Wednesday, July 18, 2007, 11:00 AM
Room 544, Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 818	**Amend Practice of Medicine Laws.-AB**	**Representative Allen**
HB 116	**Tissue Bank Accreditation.**	**Representative England, M.D. Representative Allen Representative Wright**
HB 892	**Update Licensure Act/Speech Pathologists.**	**Representative Faison**
HB 118	**Sex Offenders/Test for STDs**	**Representative Goforth Representative Ray Representative Glazier Representative Spear**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, July 18, 2007 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 18, 2007 in Room 544 of the Legislative Office Building, with fifteen members present. Senator Stan Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members and introduced the pages and sergeants-at arms.

Senator Bingham stated HB 818, ***Amend Practice of Medicine Laws.-AB,*** had been pulled from the calendar and would not be heard at this time.

Senator Bingham moved down the agenda to HB 892, ***Update Licensure Act/Speech Pathologists***, and Senator Dorsett offered the motion to hear the PCS, which passed. Representative Faison was recognized to explain the legislation. Rep. Faison stated HB 892 was a consensus bill and was an update of the Licensure Act of Speech Pathologists. Rep. Faison pointed out that everybody who was a stakeholder had gotten together and had said this was what was needed to bring the Licensure Act up-to-date. Senator Dorsett moved for a favorable report, unfavorable as to Original Bill, but favorable as to Committee Substitute Bill. The motion passed.

Senator Bingham moved back up the agenda to HB 116, ***Tissue Bank Accreditation***, which had a PCS and Senator Dr. Forrester moved to adopt the PCS for discussion. Representative Allen was recognized to explain the bill. The PCS only added a cross reference to define tissue banks and it removed a provision relating to restriction of tissue procurement in funeral establishments. She explained that a separate bill would be taking care of that particular matter. The sub-committee on Patient Safety recommended this bill, which is part of the interim Commission on Health Care. HB 116 will go to Appropriations. Rep. Allen further explained there was a company in NC that was accused of misstating the age, cause of death, and other critical health risk facts for at least five donors and in a separate case four people connected to a now defunct NJ company were charged with taking tissue without gaining proper permission. Rep. Allen stated that the FDA lightly regulates tissue collection. This bill would add certification that would protect our public. It would require that tissue banks, other than a hospital, be registered with the Food and Drug Administration and accredited by the American Association of Tissue Banks, or for the eyes, the Eye Banks Association of America. Senator Jones moved for a favorable report at the appropriate time. Senator Dr. Forrester asked if this was to decrease the black market Sale of human organs, stating that in New York City they would find a homeless man with his side cut and his kidney removed. Representative Allen responded that it was to make sure NC was eliminating a black market and to make sure any patient that received tissue could be assured it was not from someone that had cancer or AIDS. Sen. Dr. Forrester asked about the fine of $500.00 stating that was a low fine if the person taking the organ could get $10,000.00 - $20,000.00 for a kidney. Shawn Parker, Research Staff, stated that if it a misdemeanor the maximum fine was $500.00. Sen. Dorsett asked if the penalty would be raised if it was a second or third offense. Ben Popkin, Research Staff, stated that under criminal

law, the cap was no more than $500.00, which is associated with a misdemeanor offense. However, there may be other avenues to increase the penalties, maybe some type of civil penalties. Representative Allen stated this was an incremental step and it would be continually looked at to make sure the public was protected. Sen. Bingham stated there was already a motion, Unfavorable to the Bill, but favorable as to the Committee Substitute with a recommendation to be re-referred to Appropriations. The motion carried.

Senator Bingham stated the committee would hear HB 118, ***Sex Offenders/Test for STDs***, which had an amendment. Senator Dr. Purcell was recognized to explain the amendment. The amendment specifies the proper test to be used, "HIV-RNA Detection test for determining HIV infection". Senator Dr. Forrester asked how long it takes to get the results. Dr. Steve Cline, Deputy State Health Director in the Division of Public Health, stated the testing was done in the state laboratory at Public Health. On a normal routine basis the results are returned to the person who ordered it in seven days, but for a law enforcement sensitive case it can be returned in one to two days. Senator Brunstetter asked if we specify the test and a better test becomes available would there have to be more legislation to use the better one. Rep. Glazier stated that had been discussed and it would have to have new legislation, however this test needs to be used at this time in order to get the test results back in a reasonable time. Senator Purcell had made the motion for approval of the amendment, which passed. Rep. Glazier explained the Federal Law had changed and required the test to be done within 48 hours of the date of the court order and this is simply conforming to what the Feds are doing for protection of the victim. Senator Malone asked about enforcement. Ben Popkins, Research Attorney, stated that this was existing practice. He stated that enforcement would go along with any other enforcement mechanisms or court orders and if in violation of a direct court order the person could be subject to contempt of court. This is not a variation of any kind in the existing practice; it simply clarifies the test and limits the time frame. Sen. Jones asked who picked up the tab on this. Rep Glazier responded if the prisoner was incarcerated the government would have to pay and if they were not incarcerated or indigent then the person would have to pay. Dr. Steve Cline, Deputy State Health Director, stated occasionally the test comes through the local health department to the state lab and they assume the cost as they do for other HIV test already in local health department, but it has not been a burden. Senator Dr. Forrester moved for a favorable report, the motion being to roll the amendment into a Proposed Committee Substitute, favorable to the Committee Substitute, unfavorable Original Bill. The motion passed.

The meeting adjourned at 11:26 A.M.

Stan Bingham

Senator Stan Bingham, Co-Chair

William R Purcell

Senator Dr. William R. Purcell, Co-Chair

Judy F. Chriscoe

Judy Chriscoe, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, July 19, 2007

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

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

H.B. **116** Tissue Bank Accreditation.

Draft Number:	10261
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 Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, July 18, 2007

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **892** Update Licensure Act/Speech Pathologists.

Draft Number:	60385
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

Wednesday, July 18, 2007

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) **118** Sex Offenders/Test for STDs

Draft Number:	70590
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 4

HOUSE BILL 818*

Committee Substitute Favorable 5/4/07
Committee Substitute #2 Favorable 5/14/07
Committee Substitute #3 Favorable 6/12/07

Short Title: Amend Practice of Medicine Laws.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

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

"**§ 90-1A. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Medical Board.

(2) Hearing officer. – Any current or past member of the Board who is a physician, physician assistant, or nurse practitioner and has an active license or approval to practice medical acts, tasks, or functions issued by the Board, or any current or retired judge of the Office of Administrative Hearings, a State district court, a State superior court, the North Carolina Court of Appeals, the North Carolina Supreme Court, or of the federal judiciary who has an active license to practice law in North Carolina and who is a member in good standing of the North Carolina State Bar.

(3) Integrative medicine. – A diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

(4) License. – An authorization issued by the Board to a physician or physician assistant to practice medical acts, tasks, or functions.

(5) The practice of medicine or surgery. – The practice of medicine or surgery, for purposes of this Article, includes any of the following acts:

a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State.

b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual.

c. Offering or undertaking to prevent or diagnose, correct, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition.

d. Offering or undertaking to perform any surgical operation on any individual.

e. Using the designation 'Doctor,' 'Doctor of Medicine,' 'Doctor of Osteopathy,' 'Doctor of Osteopathic Medicine,' 'Physician,' 'Surgeon,' 'Physician and Surgeon,' 'Dr.,' 'M.D.,' 'D.O.,' or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of or reference to another branch of the healing arts for which the individual holds a valid license in this State or the use of the designation 'Doctor' or 'Physician' is otherwise specifically permitted by law.

f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone."

SECTION 2. G.S. 90-2.1 is repealed.

SECTION 3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.1. Powers and duties of the Board.**

(a) The Board shall:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this Article.

(4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.

(5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or nonlicensee. In the case of the death of a licensee, the rules may provide for the disposition of the medical records by the estate of the licensee. This subsection shall not apply to

records created or maintained by persons licensed under other Articles of this Chapter or to medical records maintained in the normal course of business by licensed health care institutions.

(6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.

(7) Develop educational programs to facilitate licensee awareness of provisions contained in this Article and public awareness of the role and function of the Board.

(8) Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care.

(9) Develop and implement methods to assess and improve physician practice.

(10) Develop and implement methods to ensure the ongoing competence of licensees.

(b) Nothing in subsection (a) of this section shall restrict or otherwise limit powers and duties conferred on the Board in other sections of this Article."

SECTION 4. G.S. 90-6(a) is recodified as G.S. 90-8.1; G.S. 90-6(b) and (c), respectively, are recodified as G.S. 90-8.2(a) and (b), respectively; G.S. 90-12.1 is recodified as G.S. 90-12.4; G.S. 90-12.2 is recodified as G.S. 90-12.5; G.S. 90-15 is recodified as G.S. 90-13.1; and G.S. 90-15.1 is recodified as G.S. 90-13.2.

SECTION 5. G.S. 90-8.1, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-8.1. Rules governing applicants for ~~license, examinations, etc.; appointment of subcommittees.~~licensure.**

~~(a)~~ The North Carolina Medical Board is empowered to ~~prescribe such~~adopt rules ~~as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.~~that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures."

SECTION 6. G.S. 90-8.2, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-8.2. Appointment of subcommittees.**

(a) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). ~~The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00).~~ Rules developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and shall become effective when adopted by both the North Carolina Medical Board and the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these rules.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina Board of Pharmacy to develop rules to govern the performance of medical acts by clinical pharmacist practitioners, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). ~~The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00).~~ Rules recommended by the subcommittee shall be adopted in accordance with Chapter 150B of the General Statutes by both the North Carolina Medical Board and the North Carolina Board of Pharmacy and shall not become effective until adopted by both Boards. The North Carolina Medical Board shall have responsibility for ensuring compliance with these rules."

SECTION 7. G.S. 90-9 and G.S. 90-10 are repealed.

SECTION 8. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-9.1. Requirements for licensure as a physician under this Article.**

(a) Except as provided in G.S. 90-9.2, to be eligible for licensure as a physician under this Article, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has passed each part of an examination described in G.S. 90-10.1;

(2) Is a graduate of:

a. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association and has successfully completed one year of training in a medical education program approved by the Board after graduation from medical school; or

b. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency program approved by the Board before completion of medical school; and

(3) Is of good moral character.

(b) No license may be granted to any applicant who graduated from a medical or osteopathic college that has been disapproved by the Board pursuant to rules adopted by the Board.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.2. Requirements for graduates of foreign medical schools.**

(a) To be eligible for licensure under this section, an applicant who is a graduate of a medical school not approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or the American Osteopathic Association shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed three years of training in a medical education program approved by the Board after graduation from medical school;

(2) Is of good moral character;

(3) Has a currently valid standard certificate of Educational Commission for Foreign Medical Graduates (ECFMG); and

(4) Is able to communicate in English.

(b) The Board may waive ECFMG certification if the applicant:

(1) Has passed the ECFMG examination and successfully completed an approved Fifth Pathway Program. The applicant is required to provide the original ECFMG Certification Status Report from the ECFMG; or

(2) Has been licensed in another state on the basis of written examination before the establishment of ECFMG in 1958.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.3. Requirements for licensure as a physician assistant.**

(a) To be eligible for licensure as a physician assistant, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by the Committee's predecessor or successor entities;

(2) Holds or previously held a certificate issued by the National Commission on Certification of Physician Assistants; and

(3) Is of good moral character.

(b) Before initiating practice of medical acts, tasks, or functions as a physician assistant, the physician assistant shall provide the Board the name, address, and telephone number of the physician who will supervise the physician assistant in the relevant medical setting.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate. The Board may set fees for physician assistants pursuant to rules adopted by the Board.

"**§ 90-10.1. Examinations accepted by the Board.**

The Board may administer or accept the following examinations for licensure:

(1) A State Board licensing examination.

(2) The National Board of Medical Examiners (NBME) examination or its successor.

(3) The United States Medical Licensing Examination (USMLE) of this section or its successor.

(4) The Federation Licensing Examination (FLEX) or its successor.

(5) Other examinations the Board deems equivalent to the examinations described in subdivisions (1) through (3) of this section pursuant to rules adopted by the Board."

SECTION 9. G.S. 90-11 reads as rewritten:

"§ 90-11. ~~Qualifications of applicant for license.~~Criminal background checks.

~~(a) Every applicant for a license to practice medicine or to perform medical acts, tasks, and functions as a physician 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 any such license is granted by the Board to the applicant.~~

~~(b)~~ The Department of Justice may provide a criminal record check to the Board for a person who has applied for a 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 10. G.S. 90-12 and G.S. 90-13 are repealed.

SECTION 11. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"§ 90-12A. Limited license to practice in a medical education and training program.

(a) As provided in rules adopted by the Board, the Board may issue a limited license known as a 'resident's training license' to a physician not otherwise licensed by the Board who is participating in a graduate medical education training program.

(b) A resident's training license shall become inactive at the time its holder ceases to be a resident in a training program or obtains any other license to practice medicine issued by the Board. The Board shall retain jurisdiction over the holder of the inactive license.

"§ 90-12.1A. Limited volunteer license.

(a) The Board may issue a 'military limited volunteer license' to an applicant who:

(1) Has a license to practice medicine and surgery in another state;

(2) Produces a letter from the state of licensure indicating the applicant is in good standing; and

(3) Is authorized to treat personnel enlisted in a branch of the United States armed services or veterans.

(b) The Board may issue a 'retired limited volunteer license' to an applicant who is a retired physician and has allowed his or her license to practice medicine and surgery in this State or another state to become inactive.

(c) A physician holding a limited license under this section shall comply with the continuing medical education requirements pursuant to rules adopted by the Board.

(d) The Board shall issue a limited license under this section within 30 days after an applicant provides the Board with information satisfying the requirements of this section.

(e) The holder of a limited license under this section may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients. The holder of the limited license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

(f) The holder of a limited license issued pursuant to this section who practices medicine or surgery at places other than clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

(g) The Board may, by rule, require an applicant for a limited license under this section to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-12.2A. Special purpose license.**

(a) The Board may issue a special purpose license to practice medicine to an applicant who:

(1) Holds a full and unrestricted license to practice in at least one other jurisdiction; and

(2) Does not have any current or pending disciplinary or other action against him or her by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the special purpose license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the special purpose license.

(c) The Board may adopt rules and set fees as appropriate to implement the provisions of this section.

"**§ 90-12.3. Medical school faculty license.**

(a) The Board may issue a medical school faculty license to practice medicine and surgery to a physician who:

(1) Holds a full-time appointment as either a lecturer, assistant professor, associate professor, or full professor at one of the following medical schools:

a. Duke University School of Medicine;
b. The University of North Carolina at Chapel Hill School of Medicine;
c. Wake Forest University School of Medicine; or
d. East Carolina University School of Medicine; and

(2) Is not subject to disciplinary order or other action by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the medical school faculty license issued under this section shall not practice medicine or surgery outside the confines of the medical school or an affiliate of the medical school. The holder of the medical school faculty license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the medical school faculty license.

(c) The Board may adopt rules and set fees related to issuing medical school faculty licenses. The Board may, by rule, set a time limit for the term of a medical school faculty license."

SECTION 12. G.S. 90-13.1, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-13.1. License ~~fee; salaries, fees, and expenses of Board.~~fees.**

(a) Each applicant for a license to practice medicine and surgery in this State under either G.S. ~~90-9, 90-10, or 90-13~~90-9.1 or G.S. 90-9.2 shall pay to the North Carolina Medical Board an application fee of three hundred fifty dollars ($350.00).

(b) ~~Whenever~~ Each applicant for a limited license ~~is granted as provided in~~to practice in a medical education and training program under G.S. ~~90-12, the applicant~~90-12A shall pay to the Board a fee ~~not to exceed~~of one hundred ~~fifty~~ dollars ($100.00). ~~($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 one hundred dollars ($100.00), and~~

(c) ~~where~~ An applicant for a limited volunteer license ~~to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients is granted, the applicant~~under G.S. 90-12.1A shall not pay a fee.

(d) A fee of twenty-five dollars ($25.00) shall be paid for the issuance of a duplicate license.

(e) 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.~~"

SECTION 13. G.S. 90-13.2, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-13.2. Registration every year with Board.**

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday.

(b) A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay ~~a~~ an annual registration fee of one hundred seventy-five dollars ($175.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ($125.00) and those who have a limited volunteer license shall pay an annual registration fee of twenty-five dollars ($25.00). However, licensees who have a limited license to practice for the purpose of education and training under G.S. 90-12A shall not be required to pay more than one annual registration fee for each year of training.

(c) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.

(d) For purposes of annual registration, the Board shall use a simplified registration form which allows registrants to confirm information on file with the Board.

(e) A physician who fails to register as required by this section shall pay an additional fee of fifty dollars ($50.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is automatically inactive. The Board shall retain jurisdiction over the holder of the inactive license.

(f) Except as provided in G.S. ~~90-12(d),~~90-12.1A, a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee.

(g) Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. ~~90-13.~~90-13.1."

SECTION 14. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-13.3. Salaries, fees, expenses of the Board.**

(a) 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.

(b) The per diem compensation of Board members shall not exceed two hundred dollars ($200.00) per member for time spent in the performance and discharge of duties as a member. Any unexpended sum 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."

SECTION 15. G.S. 90-14 reads as rewritten:

"**§ 90-14. ~~Revocation, suspension, annulment or denial of license~~Disciplinary Authority.**

(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, an application, request or petition for reinstatement or reactivation of a license, an annual registration of a license, or an investigation or inquiry by the Board.

(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 © 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.~~patients or failing to maintain acceptable standards of one or more areas of professional physician practice. 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, 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.

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 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.

...."

SECTION 16. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before disciplinary action.~~revocation or suspension of a license.~~**

Before the Board shall ~~revoke, restrict or suspend~~take disciplinary action against any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 17. G.S. 90-14.4 is repealed.

SECTION 18. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of hearing committee and ~~depositions.~~depositions; appointment of hearing officers.**

(a) The Board, in its discretion, may designate in writing three or more ~~of its members~~hearing officers 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.

(d) Hearing officers are entitled to receive per diem compensation and reimbursement for expenses as authorized by the Board. The per diem compensation shall not exceed the amount allowed by G.S. 90-13.3."

SECTION 19. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

(a) ~~In~~ Except as otherwise provided in proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, in proceedings held pursuant to this Article, the ~~licensee~~ individual under investigation may call witnesses, including medical practitioners licensed in the United ~~States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony.~~States with training and experience in the same field of practice as the individual under investigation and familiar with the standard of care among members of the same health care profession in North Carolina. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article. Documentary evidence may be received in the form of a copy or excerpt or may be incorporated by reference, if the materials so incorporated are available for examination by the parties. Upon timely request, a party shall be given an opportunity to compare the copy with the original if available.

(d) When evidence is not reasonably available under the Rules of Civil Procedure and Rules of Evidence to show relevant facts, then the most reliable and substantial evidence available shall be admitted."

SECTION 20. G.S. 90-14.8 reads as rewritten:

"**§ 90-14.8. Appeal from Board's decision taking disciplinary action on a license, ~~revoking or suspending a license.~~**

A physician whose license is revoked or suspended by the Board may obtain a review of the decision of the Board in the Superior Court of Wake County ~~or in the superior court in the county in which the hearing was held or upon agreement of the parties to the appeal in any other superior court of the State,~~ upon filing with the secretary of the Board a written notice of appeal within 20 days after the date of the

service of the decision of the Board, stating all exceptions taken to the decision of the Board and indicating the court in which the appeal is to be heard.

Within 30 days after the receipt of a notice of appeal as herein provided, the Board shall prepare, certify and file with the clerk of ~~the superior court in the county to which the appeal is directed~~the Superior Court of Wake County the record of the case comprising a copy of the charges, notice of hearing, transcript of testimony, and copies of documents or other written evidence produced at the hearing, decision of the Board, and notice of appeal containing exceptions to the decision of the Board."

SECTION 21. G.S. 90-14.10 reads as rewritten:

"**§ 90-14.10. Scope of review.**

Upon the review of the Board's decision ~~revoking or suspending~~taking disciplinary action on a license, the case shall be heard by the judge without a jury, upon the record, except that in cases of alleged omissions or errors in the record, testimony thereon may be taken by the court. The court may affirm the decision of the Board or remand the case for further proceedings; or it may reverse or modify the decision if the substantial rights of the accused physician have been prejudiced because the findings or decisions of the Board are in violation of substantive or procedural law, or are not supported by competent, material, and substantial evidence admissible under this Article, or are arbitrary or capricious. At any time after the notice of appeal has been filed, the court may remand the case to the Board for the hearing of any additional evidence which is material and is not cumulative and which could not reasonably have been presented at the hearing before the Board."

SECTION 22. 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.**

(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.~~license.

(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 by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, complaint or, disciplinary 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 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~~ subsections (d) and (f) 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.~~Board and transcripts of any deposition taken by Board counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.

(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) When the Board receives a complaint regarding the care of a patient, the Board shall inform the complainant of the disposition of the Board's inquiry into the complaint and the Board's basis for that disposition. Upon written request of a patient, the Board may provide the patient a licensee's written response to a complaint filed by the patient with the Board regarding the patient's care. Upon written request of a complainant, who is not the patient but is authorized by State and federal law to receive protected health information about the patient, the Board may provide the complainant a licensee's written response to a complaint filed with the Board regarding the patient's care. Any information furnished to the patient or complainant pursuant to this subsection shall be inadmissible in evidence in any civil proceeding. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were included in the Board's review or were the subject of information furnished to the patient or complainant pursuant to this subsection."

~~(f)~~(g) 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)~~(h) 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)~~(i) If investigative information in the possession of the Board, its employees, or agents indicates that a crime may have been committed, the Board ~~shall~~ may report the information to the appropriate law enforcement ~~agency.~~agency or district attorney of the district in which the offense was committed.

~~(i)~~(j) The Board shall cooperate with and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the investigating ~~agency.~~agency or district attorney. Information disclosed by the Board to an investigative agency or district attorney remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation.

~~(j)~~(k) 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)~~(l) The Board, its members and staff, may release confidential or nonpublic information to any health care licensure board in this State or another state or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities 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 23. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; ~~practicing defined;~~ penalties.**

(a) No person shall perform any act constituting the practice of medicine or surgery, as defined in this Article, 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, 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.

~~(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.~~

(c) The following shall not constitute practicing medicine or surgery as defined in ~~subsection (b) of this section:~~this Article:

(1) The administration of domestic or family ~~remedies in cases of emergency.~~remedies.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and rules developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of ~~chiropody~~podiatric medicine and surgery by any legally licensed ~~chiropodist~~podiatric physician when engaged in the practice of ~~chiropody, and without the use of any drug.~~podiatry as defined in Article 12A of this Chapter.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(11a) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery so long as:

a. The physician or surgeon has an oral or written agreement with a sports team to provide general or emergency medical care to the team members, coaching staff, or families traveling with the team for a specific sporting event taking place in this State; and

b. The physician or surgeon does not provide care or consultation to any person residing in this State other than an individual described in sub-subdivision a. of this subdivision.

The exemption shall remain in force while the physician or surgeon is traveling with the team. The exemption shall not exceed 10 days per individual sporting event. However, the executive director of the Board may grant a physician or surgeon additional time for exemption of up to 20 additional days per individual sporting event.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a

human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State.

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.

b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.
c. The physician receives no compensation for the services.
d. The physician provides those services within this State for no more than 30 days per calendar year.
e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

SECTION 24. G.S. 90-18.1(a) reads as rewritten:

"(a) Any person who is licensed under the provisions of G.S. ~~90-11~~90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician may use the title "physician assistant". Any other person who uses the title in any form or holds out to be a physician assistant or to be so licensed, shall be deemed to be in violation of this Article."

SECTION 25. G.S. 90-18.1 is amended by adding the following new subsections to read:

"(g) Any person who is licensed under G.S. 90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician shall comply with each of the following:

(1) Maintain a current and active license to practice in this State.
(2) Maintain an active registration with the Board.
(3) Have a current Intent to Practice form filed with the Board.

(h) A physician assistant serving active duty in the United States military is exempt from the requirements of subdivision (g)(3) of this section.

(i) A physician assistant's license shall become inactive any time the holder fails to comply with the requirements of subsection (g) of this section. A physician assistant with an inactive license shall not practice medical acts, tasks, or functions. The Board shall retain jurisdiction over the holder of the inactive license."

SECTION 26. G.S. 90-21 is repealed.

SECTION 27. This act becomes effective October 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

HOUSE BILL 116

Short Title:	Tissue Bank Accreditation.	(Public)
Sponsors:	Representatives Allen, Wright, England (Primary Sponsors); Carney, Cole, Faison, Folwell, Glazier, Jones, Justice, Justus, Ross, Tucker, Underhill, Wainwright, E. Warren, Weiss, and Williams.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CERTAIN TISSUE BANKS OPERATING IN NORTH CAROLINA TO BE ACCREDITED BY THE AMERICAN ASSOCIATION OF TISSUE BANKS OR THE EYE BANK ASSOCIATION OF AMERICA.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 8A.

"Regulation of Tissue Banks.

"**§ 131E- 171. Registration and accreditation requirements.**

(a) Any tissue bank that recovers human tissue at a location outside of a hospital, when such tissue is intended for human transplantation, shall be registered with the Food and Drug Administration and accredited by the American Association of Tissue Banks (AATB), or accredited by the Eye Bank Association of America (EBAA), unless the establishment is an organ procurement organization that has been designated by the federal Secretary for Health and Human Services and is registered with the Food and Drug Administration as a tissue bank.

(b) For purposes of this Article, 'human tissue' means musculoskeletal tissue, including bone, tendons, ligaments, fascia, cartilage, and related soft tissues, skin, cardiac tissue, dura mater, and ocular tissue. Human tissue in this Article shall not include oocytes, semen, embryos, or stem cells from peripheral blood or umbilical cord blood sources.

"**§ 131E-172. Inspection, enforcement, penalties.**

(a) The Department is authorized to inspect the records of any tissue bank engaged in the recovery of human tissue for human transplantation in the State to ascertain compliance with the registration and accreditation requirements of this Article.

(b) Notwithstanding the existence or pursuit of any other remedy, the Department may maintain an action in the name of the State for injunctive relief or other process against any tissue bank to restrain or prevent recovery of human tissue for human transplantation without the required registration or accreditation or otherwise restrain or prevent substantial noncompliance with this Article or the rules adopted pursuant to it.

(c) If any person hinders the proper performance of duty of the Department in carrying out the provisions of this Article, the Department may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance.

(d) Any person who knowingly and willfully engages in the recovery of human tissue for human transplantation without registration with the Food and Drug Administration or accreditation by the AATB or EBAA as required by this Article is guilty of a Class 3 misdemeanor and upon conviction is liable only for a fine of not more than five hundred dollars ($500.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense."

SECTION 2. G.S. 90-210.25 is amended by adding a new subsection to read:

"(e1) No funeral establishment shall permit the recovery of human tissue from a dead human body in its custody and control except in accordance with Article 8A of Chapter 131E of the General Statutes."

SECTION 3. This act becomes effective October 1, 2007, and applies to tissue banks engaged in the recovery of human tissue or cells for human transplantation on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 116
PROPOSED SENATE COMMITTEE SUBSTITUTE H116-CSSQ-53 [v.1]

7/13/2007 11:57:16 AM

Short Title: Tissue Bank Accreditation. (Public)

Sponsors:

Referred to:

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CERTAIN TISSUE BANKS OPERATING IN NORTH CAROLINA TO BE ACCREDITED BY THE AMERICAN ASSOCIATION OF TISSUE BANKS OR THE EYE BANK ASSOCIATION OF AMERICA.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 8A.

"Regulation of Tissue Banks.

"**§ 131E- 171. Registration and accreditation requirements.**

(a) Any tissue bank that recovers human tissue at a location outside of a hospital, when such tissue is intended for human transplantation, shall be registered with the Food and Drug Administration and accredited by the American Association of Tissue Banks (AATB), or accredited by the Eye Bank Association of America (EBAA), unless the establishment is an organ procurement organization that has been designated by the federal Secretary for Health and Human Services and is registered with the Food and Drug Administration as a tissue bank.

(b) For purposes of this Article, 'human tissue' means musculoskeletal tissue, including bone, tendons, ligaments, fascia, cartilage, and related soft tissues, skin, cardiac tissue, dura mater, and ocular tissue. Human tissue in this Article shall not include oocytes, semen, embryos, or stem cells from peripheral blood or umbilical cord blood sources.

"**§ 131E-172. Inspection, enforcement, penalties.**

(a) The Department is authorized to inspect the records of any tissue bank engaged in the recovery of human tissue for human transplantation in the State to ascertain compliance with the registration and accreditation requirements of this Article.

(b) Notwithstanding the existence or pursuit of any other remedy, the Department may maintain an action in the name of the State for injunctive relief or other process

against any tissue bank to restrain or prevent recovery of human tissue for human transplantation without the required registration or accreditation or otherwise restrain or prevent substantial noncompliance with this Article or the rules adopted pursuant to it.

(c) If any person hinders the proper performance of duty of the Department in carrying out the provisions of this Article, the Department may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance.

(d) Any person who knowingly and willfully engages in the recovery of human tissue for human transplantation without registration with the Food and Drug Administration or accreditation by the AATB or EBAA as required by this Article is guilty of a Class 3 misdemeanor and upon conviction is liable only for a fine of not more than five hundred dollars ($500.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense."

SECTION 2. This act becomes effective October 1, 2007, and applies to tissue banks engaged in the recovery of human tissue or cells for human transplantation on or after that date.

HOUSE BILL 116:
Tissue Bank Accreditation

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 17, 2007
Introduced by:	Reps. Allen, Wright, England	**Summary by:**	Shawn Parker
Version:	PCS to First Edition H116-CSSQ-53		Legislative Analyst

SUMMARY: ***House Bill 116 would enact a new Article 8A of Chapter 131E of the General Statutes to provide for the regulation of tissue banks in the State. Article 8A "Regulation of Tissue Banks" would set forth registration and accreditation requirements for tissue banks, would authorize the Department of Health and Human Services to inspect tissue banks and enforce compliance with requirements of Article 8A.***

The Proposed Committee Substitute adds a cross reference to a definition of the term "tissue banks" and removes the provision relating to restrictions of tissue procurement in funeral establishments.

BILL ANALYSIS: House Bill 116 would enact a new Article 8A (Regulation of Tissue Banks) of Chapter 131E of the General Statutes to provide for the regulation of tissue banks in the State. Article 8A would set forth provisions establishing registration and accreditation requirements for tissue banks, and provisions that would authorize the Department of Health and Human Services (Department) to inspect tissue banks and enforce compliance with the requirements of the provisions of 8A.

Registration and accreditation requirements – G.S. 131E-171 would require that any tissue bank that recovers human tissue at a location outside of a hospital that is intended for transplantation must be registered with the Food and Drug Administration (FDA) and be accredited by the American Association of Tissue Banks (AATB) or the Eye Bank Association of America (EBAA). Organ procurements organizations designated by the federal Secretary of Health and Human Services and registered as a tissue bank with the FDA need not be accredited by the AATB or EBAA.

Inspection, enforcement, penalties – G.S. 131E-172 would authorize the Department to inspect records of any tissue bank to ascertain compliance with the registration and accreditation requirements of Article 8A.Subsection (b) would authorize the Department to pursue injunctive or other relief to restrain or prevent recovery of tissue by tissue banks not in compliance with the provisions of Article 8A. Subsection (d) would create a class 3 misdemeanor violation for 'any person who...engages in recovery of human tissue for transplantation without complying with the accreditation and registration requirements of Article 8A and allows for imposition of fines of not more than $500 for each violation.

EFFECTIVE DATE: The act would be effective October 1, 2007 and would apply to tissue banks engaging in the recovery of human tissue or cells for human transplantation on or after that date.

Ben Popkin, counsel to House Health, substantially contributed to this summary.

H0116e1-SMSQ-CSSQ-53

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 116
PROPOSED SENATE COMMITTEE SUBSTITUTE H116-PCS10261-SQ-53

Short Title: Tissue Bank Accreditation. (Public)

Sponsors:

Referred to:

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE CERTAIN TISSUE BANKS OPERATING IN NORTH CAROLINA TO BE ACCREDITED BY THE AMERICAN ASSOCIATION OF TISSUE BANKS OR THE EYE BANK ASSOCIATION OF AMERICA.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 8A.

"Regulation of Tissue Banks.

"**§ 131E-171. Registration and accreditation requirements.**

(a) Any tissue bank that recovers human tissue at a location outside of a hospital, when such tissue is intended for human transplantation, shall be registered with the Food and Drug Administration and accredited by the American Association of Tissue Banks (AATB), or accredited by the Eye Bank Association of America (EBAA), unless the establishment is an organ procurement organization that has been designated by the federal Secretary for Health and Human Services and is registered with the Food and Drug Administration as a tissue bank.

(b) For purposes of this Article, 'human tissue' means musculoskeletal tissue, including bone, tendons, ligaments, fascia, cartilage, and related soft tissues, skin, cardiac tissue, dura mater, and ocular tissue. Human tissue in this Article shall not include oocytes, semen, embryos, or stem cells from peripheral blood or umbilical cord blood sources.

"**§ 131E-172. Inspection, enforcement, penalties.**

(a) The Department is authorized to inspect the records of any tissue bank engaged in the recovery of human tissue for human transplantation in the State to ascertain compliance with the registration and accreditation requirements of this Article.

(b) Notwithstanding the existence or pursuit of any other remedy, the Department may maintain an action in the name of the State for injunctive relief or other process

against any tissue bank to restrain or prevent recovery of human tissue for human transplantation without the required registration or accreditation or otherwise restrain or prevent substantial noncompliance with this Article or the rules adopted pursuant to it.

(c) If any person hinders the proper performance of duty of the Department in carrying out the provisions of this Article, the Department may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance.

(d) Any person who knowingly and willfully engages in the recovery of human tissue for human transplantation without registration with the Food and Drug Administration or accreditation by the AATB or EBAA as required by this Article is guilty of a Class 3 misdemeanor and upon conviction is liable only for a fine of not more than five hundred dollars ($500.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense."

SECTION 2. This act becomes effective October 1, 2007, and applies to tissue banks engaged in the recovery of human tissue or cells for human transplantation on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 892

Committee Substitute Favorable 5/21/07
Committee Substitute #2 Favorable 5/29/07

Short Title: Update Licensure Act/Speech Pathologists. (Public)

Sponsors:

Referred to:

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LICENSURE ACT FOR SPEECH AND LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-293 reads as rewritten:

"**§ 90-293. Definitions.**

As used in this Article, unless the context otherwise requires:

(1) "Audiologist" means any person who engages in the practice of audiology. A person is deemed to be an audiologist if he offers services to the public under any title incorporating the terms of "audiology," "audiologist," "audiological," "hearing clinic," "hearing clinician," "hearing therapist," or any similar title or description of service.

(2) "Board" means the Board of Examiners for Speech and Language Pathologists and Audiologists.

(3) "License" means a license issued by the Board under the provisions of this Article, including a temporary license.

(4) "Person" means an individual, organization, or corporate body, except that only individuals can be licensed under this Article.

(5) "Speech and language pathologist" means any person who represents himself or herself to the public by title or by description of services, methods, or procedures as one who evaluates, examines, instructs, ~~or counsels~~counsels, or treats persons suffering from conditions or disorders affecting speech and ~~language.~~language or swallowing. A person is deemed to be a speech and language pathologist if ~~he~~ the person offers such services under any title incorporating the words "speech pathology," "speech pathologist," "speech correction," "speech correctionist," "speech therapy," "speech therapist," "speech clinic,"

"speech clinician," "language pathologist," "language therapist," "logopedist," "communication disorders," "communicologist," "voice therapist," "voice pathologist," or any similar title or description of service.

(6) "The practice of audiology" means the application of principles, methods, and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to ~~hearing and disorders of~~ hearing and vestibular disorders for the purpose of identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals ~~and/or~~or groups of individuals. For the purpose of this subdivision, the words "habilitation" and "rehabilitation" shall include auditory training, speech reading, aural rehabilitation, hearing aid use evaluation and recommendations, and fabrication of earmolds and similar accessories for clinical testing ~~purposes only.~~purposes.

(7) "The practice of speech and language pathology" means the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, ~~counseling,~~counseling, treating, instruction, habilitation, or rehabilitation related to the development and disorders of speech, voice, ~~or language~~language, and swallowing for the purpose of identifying, preventing, ameliorating, or modifying such disorders.

(8) Repealed by Session Laws 1987, c. 665, s. 1.

(9) "Accredited college or university" means an institution of higher learning accredited by the Southern Association of Colleges and Universities, or accredited by a similarly recognized association of another locale."

SECTION 2. G.S. 90-294(c) reads as rewritten:

"(c) The provisions of this Article do not apply to:

(1) The activities, services and use of an official title by a person employed by an agency of the federal government and solely in connection with such employment.

(2) The activities and services of a student or trainee in speech and language pathology or audiology pursuing a course of study in an accredited college or university, or working in a training center program approved by the Board, if these activities and services constitute a part of such person's course of study.

(3) Repealed by Session Laws 1987, c. 665, s. 2.

(4) A person who holds a valid and current credential as a speech and language pathologist or audiologist issued by the North Carolina Department of Public Instruction or who is employed by the North Carolina Schools for the Deaf and Blind, if such person practices speech and language pathology or audiology in a salaried position solely within the confines or under the jurisdiction of the Department

of Public Instruction or the Department of Health and Human Services respectively.

~~(5) A physician licensed to practice medicine.~~

~~(6) Persons performing audiometric screenings and whose work is under the supervision of a licensed physician, or licensed audiologist.~~

~~(7) Persons who are now or may become engaged in counseling or instructing laryngectomees in the methods, techniques, or problems of learning to speak again.~~"

SECTION 3.(a) G.S. 90-294(d) reads as rewritten:

"(d) Nothing in this Article shall apply to a physician licensed to practice medicine, or to any person employed by ~~such~~ a physician licensed to practice medicine in the course of ~~his~~ the physician's practice of medicine."

SECTION 3.(b) G.S. 90-294 is amended by adding a new subsection to read:

"(i) Nothing in this Article shall apply to a licensed occupational therapy practitioner providing evaluation and treatment of swallowing disorders, cognitive/communication deficits, and balance functions within the context of occupational therapy practice."

SECTION 4. G.S. 90-295 reads as rewritten:

"**§ 90-295. Qualifications of applicants for permanent licensure.**

(a) To be eligible for permanent licensure by the Board as a speech and language ~~pathologist or audiologist,~~pathologist, the applicant must:

(1) Possess at least a master's degree in speech and language pathology ~~or audiology~~ or qualifications deemed equivalent by the Board under ~~regulations~~ rules duly adopted by the Board under this Article. ~~Such~~ The degree or equivalent qualifications shall be from an accredited institution.

(2) Submit transcripts from one or more accredited colleges or universities presenting evidence of the completion of ~~60~~ 75 semester hours constituting a well-integrated program of course study dealing with the normal aspects of human communication, development thereof, disorders thereof, and clinical techniques for evaluation and management of such disorders.

a. ~~Twelve~~ Fifteen of these ~~60~~ 75 semester hours must be obtained in courses that provide information that pertains to normal development and use of speech, language and hearing.

b. ~~Thirty~~ Thirty-six of these ~~60~~ 75 semester hours must be in courses that provide information relative to communication disorders and information about and training in evaluation and management of speech, language, and hearing disorders. At least 24 of these 30 semester hours must be in courses in ~~the professional area (speech and language pathology or audiology) for which the license is requested, and no less than six semester hours may be in audiology for the license in speech and~~

~~language pathology or in speech and language pathology for the license in audiology. Moreover, no more than six semester hours may be in courses that provide credit for clinical practice obtained during academic training.~~speech and language pathology.

c. Credit for study of information pertaining to related fields that augment the work of the clinical practitioner of speech and language pathology ~~and/or~~or audiology may also apply toward the total ~~60~~ 75 semester hours.

d. ~~Thirty~~ Thirty-six of the total ~~60~~ 75 semester hours that are required for a license must be in courses that are acceptable toward a graduate degree by the college or university ~~in~~ at which they are taken. Moreover, 21 of those ~~30 semester hours must be within the 24 semester hours required in the professional area (speech and language pathology or audiology) for which the license is requested or within the six semester hours required in the other area.~~semester hours must be in graduate level courses in speech and language pathology.

(3) Submit evidence of the completion of a minimum of ~~300~~ 400 clock hours of supervised, direct clinical experience with individuals who present a variety of communication disorders. This experience must have been obtained within the training institution or in one of its cooperating ~~programs.~~programs in the following areas: (i) Speech – Adult (200 diagnostic and 200 therapeutic); Children (200 diagnostic and 200 therapeutic); or (ii) Language – Adult (200 diagnostic and 200 therapeutic); Children (200 diagnostic and 200 therapeutic). Each new applicant must submit a verified clinical clock hour summary sheet signed by the clinic or program director, in addition to completion of the license application.

(4) Present written evidence ~~from a licensed and/or American Speech and Hearing Association certified speech and language pathologist or audiologist supervisor of nine months of full-time professional experience in which bona fide clinical work has been accomplished in the major professional area (speech and language pathology or audiology) in which the license is being sought.~~ of nine months of full-time professional experience in which bona fide clinical work has been accomplished in speech and language pathology. The professional work must have been supervised by a speech and language pathologist who is State-licensed or certified by the American Speech-Language-Hearing Association. This experience must follow the completion of the requirements listed in subdivisions (1), (2) and (3). Full time is defined as at least nine months in a calendar year and a minimum of 30 hours per week. Half time is defined as at least 18 months in two calendar years and a minimum of

20 hours per week. The supervision must be performed by a person who holds a valid license under this Article, or certificate of clinical competence from the American Speech-Language-Hearing Association, in ~~the specific area for which licensure is sought.~~speech and language pathology.

(5) Pass an examination established or approved by the Board.

(b) To be eligible for permanent licensure by the Board as an audiologist, the applicant must:

(1) Possess a doctoral degree in audiology or qualifications deemed equivalent by the Board under rules duly adopted by the Board under this Article. The degree or equivalent qualifications shall be from an accredited institution.

(2) Persons who were engaged in the practice of audiology and do not possess a doctoral degree in audiology before October 1, 2007, shall be exempt from the degree requirement in subdivision (1) of this subsection provided those persons remain continuously licensed in the field.

(3) Submit transcripts from one or more accredited colleges or universities presenting evidence of the completion of 90 semester hours constituting a well-integrated program of course study dealing with the normal aspects of human communication, the development of human communication, the disorders associated with human communication, and the clinical techniques for evaluation and management of such disorders.

(4) Present written evidence documenting 1,800 clock hours of professional experience directly supervised by an audiologist who is State-licensed or certified by the American Speech-Language-Hearing Association or other Board-approved agency. The clock hours of professional experience must be with individuals who present a variety of communication and auditory disorders and must have been obtained within the training program at an accredited college or university or in one of its cooperating programs.

(5) Pass an examination established or approved by the Board."

SECTION 5. G.S. 90-303(a) reads as rewritten:

"(a) There shall be a Board of Examiners for Speech and Language Pathologists and Audiologists, which shall be composed of seven members, who shall all be residents of this State. Two members shall have a paid work experience in audiology for at least five years and hold a ~~certificate of clinical competence in audiology of the American Speech and Hearing Association.~~North Carolina license as an audiologist. Two members shall have paid work experience in speech pathology for at least five years and hold a ~~certificate of clinical competence in speech pathology of the American Speech and Hearing Association.~~North Carolina license as a speech and language pathologist. One member shall be a physician who is licensed to practice medicine in the State of North Carolina. Two members shall be appointed by the Governor to

represent the interest of the public at large. These two members shall be neither licensed speech and language pathologists nor audiologists. These members shall be appointed not later than July 1, 1981; one shall be initially appointed for a term of two years; the other shall be appointed for a term of three years. Thereafter all public members shall serve three-year terms."

SECTION 6. G.S. 90-304(a)(3) reads as rewritten:

"(a) The powers and duties of the Board are as follows:

...

(3) To adopt responsible rules ~~and regulations~~including ~~but not limited to regulations which~~rules that establish ethical standards of practice and require continuing professional education and to amend or repeal the same."

SECTION 7. Section 4 of this act becomes effective October 1, 2007. The remaining sections are effective when this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 892

Committee Substitute Favorable 5/21/07

Committee Substitute #2 Favorable 5/29/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H892-CSSQ-46 [v.1]

6/28/2007 11:30:42 AM

Short Title: Update Licensure Act/Speech Pathologists. (Public)

Sponsors:

Referred to:

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LICENSURE ACT FOR SPEECH AND LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-293 reads as rewritten:

"**§ 90-293. Definitions.**

As used in this Article, unless the context otherwise requires:

(1) "Audiologist" means any person who engages in the practice of audiology. A person is deemed to be an audiologist if he offers services to the public under any title incorporating the terms of "audiology," "audiologist," "audiological," "hearing clinic," "hearing clinician," "hearing therapist," or any similar title or description of service.

(2) "Board" means the Board of Examiners for Speech and Language Pathologists and Audiologists.

(3) "License" means a license issued by the Board under the provisions of this Article, including a temporary license.

(4) "Person" means an individual, organization, or corporate body, except that only individuals can be licensed under this Article.

(5) "Speech and language pathologist" means any person who represents himself or herself to the public by title or by description of services, methods, or procedures as one who evaluates, examines, instructs, ~~or~~ ~~counsels~~counsels, or treats persons suffering from conditions or disorders affecting speech and ~~language.~~language or swallowing. A person is deemed to be a speech and language pathologist if ~~he~~ the person offers such services under any title incorporating the words

"speech pathology," "speech pathologist," "speech correction," "speech correctionist," "speech therapy," "speech therapist," "speech clinic," "speech clinician," "language pathologist," "language therapist," "logopedist," "communication disorders," "communicologist," "voice therapist," "voice pathologist," or any similar title or description of service.

(6) "The practice of audiology" means the application of principles, methods, and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to ~~hearing and disorders of~~ hearing and vestibular disorders for the purpose of identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals ~~and/or~~or groups of individuals. For the purpose of this subdivision, the words "habilitation" and "rehabilitation" shall include auditory training, speech reading, aural rehabilitation, hearing aid use evaluation and recommendations, and fabrication of earmolds and similar accessories for clinical testing ~~purposes only.~~purposes.

(7) "The practice of speech and language pathology" means the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, ~~counseling.~~counseling, treating, instruction, habilitation, or rehabilitation related to the development and disorders of speech, voice, ~~or language~~language, and swallowing for the purpose of identifying, preventing, ameliorating, or modifying such disorders.

(8) Repealed by Session Laws 1987, c. 665, s. 1.

(9) "Accredited college or university" means an institution of higher learning accredited by the Southern Association of Colleges and Universities, or accredited by a similarly recognized association of another locale."

SECTION 2. G.S. 90-294(c) reads as rewritten:

"(c) The provisions of this Article do not apply to:

(1) The activities, services and use of an official title by a person employed by an agency of the federal government and solely in connection with such employment.

(2) The activities and services of a student or trainee in speech and language pathology or audiology pursuing a course of study in an accredited college or university, or working in a training center program approved by the Board, if these activities and services constitute a part of such person's course of study.

(3) Repealed by Session Laws 1987, c. 665, s. 2.

(4) A person who holds a valid and current credential as a speech and language pathologist or audiologist issued by the North Carolina Department of Public Instruction or who is employed by the North Carolina Schools for the Deaf and Blind, if such person practices

speech and language pathology or audiology in a salaried position solely within the confines or under the jurisdiction of the Department of Public Instruction or the Department of Health and Human Services respectively.

~~(5) A physician licensed to practice medicine.~~

~~(6) Persons performing audiometric screenings and whose work is under the supervision of a licensed physician, or licensed audiologist.~~

~~(7) Persons who are now or may become engaged in counseling or instructing laryngectomees in the methods, techniques, or problems of learning to speak again.~~"

SECTION 3.(a) G.S. 90-294(d) reads as rewritten:

"(d) Nothing in this Article shall apply to a physician licensed to practice medicine, or to any person employed by ~~such~~ a physician licensed to practice medicine in the course of ~~his~~ the physician's practice of medicine."

SECTION 3.(b) G.S. 90-294 is amended by adding a new subsection to read:

"(i) Nothing in this Article shall apply to a licensed physical therapy or occupational therapy practitioner providing evaluation and treatment of swallowing disorders, cognitive/communication deficits, and balance functions within the context of their licensed practice."

SECTION 4. G.S. 90-295 reads as rewritten:

"**§ 90-295. Qualifications of applicants for permanent licensure.**

(a) To be eligible for permanent licensure by the Board as a speech and language ~~pathologist or audiologist,~~pathologist, the applicant must:

(1) Possess at least a master's degree in speech and language pathology ~~or audiology~~ or qualifications deemed equivalent by the Board under ~~regulations~~ rules duly adopted by the Board under this Article. ~~Such~~ The degree or equivalent qualifications shall be from an accredited institution.

(2) Submit transcripts from one or more accredited colleges or universities presenting evidence of the completion of ~~60~~ 75 semester hours constituting a well-integrated program of course study dealing with the normal aspects of human communication, development thereof, disorders thereof, and clinical techniques for evaluation and management of such disorders.

a. ~~Twelve~~ Fifteen of these ~~60~~ 75 semester hours must be obtained in courses that provide information that pertains to normal development and use of speech, language and hearing.

b. ~~Thirty~~ Thirty-six of these ~~60~~ 75 semester hours must be in courses that provide information relative to communication disorders and information about and training in evaluation and management of speech, language, and hearing disorders. At least 24 of these 30 semester hours must be in courses in ~~the professional area (speech and language pathology or audiology)~~

~~for which the license is requested, and no less than six semester hours may be in audiology for the license in speech and language pathology or in speech and language pathology for the license in audiology. Moreover, no more than six semester hours may be in courses that provide credit for clinical practice obtained during academic training.~~speech and language pathology.

c. Credit for study of information pertaining to related fields that augment the work of the clinical practitioner of speech and language pathology ~~and/or~~or audiology may also apply toward the total ~~60~~75 semester hours.

d. ~~Thirty~~Thirty-six of the total ~~60~~75 semester hours that are required for a license must be in courses that are acceptable toward a graduate degree by the college or university ~~in~~at which they are taken. Moreover, 21 of those ~~30 semester hours must be within the 24 semester hours required in the professional area (speech and language pathology or audiology) for which the license is requested or within the six semester hours required in the other area.~~semester hours must be in graduate level courses in speech and language pathology.

(3) Submit evidence of the completion of a minimum of ~~300~~400 clock hours of supervised, direct clinical experience with individuals who present a variety of communication disorders. This experience must have been obtained within the training institution or in one of its cooperating ~~programs.~~programs in the following areas: (i) Speech – Adult (200 diagnostic and 200 therapeutic); Children (200 diagnostic and 200 therapeutic); or (ii) Language – Adult (200 diagnostic and 200 therapeutic); Children (200 diagnostic and 200 therapeutic). Each new applicant must submit a verified clinical clock hour summary sheet signed by the clinic or program director, in addition to completion of the license application.

(4) Present written evidence ~~from a licensed and/or American Speech and Hearing Association certified speech and language pathologist or audiologist supervisor of nine months of full-time professional experience in which bona fide clinical work has been accomplished in the major professional area (speech and language pathology or audiology) in which the license is being sought.~~ of nine months of full-time professional experience in which bona fide clinical work has been accomplished in speech and language pathology. The professional work must have been supervised by a speech and language pathologist who is State-licensed or certified by the American Speech-Language-Hearing Association. This experience must follow the completion of the requirements listed in subdivisions (1), (2) and (3). Full time is defined as at least nine months in a

calendar year and a minimum of 30 hours per week. Half time is defined as at least 18 months in two calendar years and a minimum of 20 hours per week. The supervision must be performed by a person who holds a valid license under this Article, or certificate of clinical competence from the American Speech-Language-Hearing Association, in ~~the specific area for which licensure is sought.~~speech and language pathology.

(5) Pass an examination established or approved by the Board.

(b) To be eligible for permanent licensure by the Board as an audiologist, the applicant must:

(1) Possess a doctoral degree in audiology or qualifications deemed equivalent by the Board under rules duly adopted by the Board under this Article. The degree or equivalent qualifications shall be from an accredited institution.

(2) Persons who were engaged in the practice of audiology and do not possess a doctoral degree in audiology before October 1, 2007, shall be exempt from the degree requirement in subdivision (1) of this subsection provided those persons remain continuously licensed in the field.

(3) Submit transcripts from one or more accredited colleges or universities presenting evidence of the completion of 90 semester hours constituting a well-integrated program of course study dealing with the normal aspects of human communication, the development of human communication, the disorders associated with human communication, and the clinical techniques for evaluation and management of such disorders.

(4) Present written evidence documenting 1,800 clock hours of professional experience directly supervised by an audiologist who is State-licensed or certified by the American Speech-Language-Hearing Association or other Board-approved agency. The clock hours of professional experience must be with individuals who present a variety of communication and auditory disorders and must have been obtained within the training program at an accredited college or university or in one of its cooperating programs.

(5) Pass an examination established or approved by the Board."

SECTION 5. G.S. 90-303(a) reads as rewritten:

"(a) There shall be a Board of Examiners for Speech and Language Pathologists and Audiologists, which shall be composed of seven members, who shall all be residents of this State. Two members shall have a paid work experience in audiology for at least five years and hold a ~~certificate of clinical competence in audiology of the American Speech and Hearing Association.~~North Carolina license as an audiologist. Two members shall have paid work experience in speech pathology for at least five years and hold a ~~certificate of clinical competence in speech pathology of the American Speech and Hearing Association.~~North Carolina license as a speech and language

pathologist. One member shall be a physician who is licensed to practice medicine in the State of North Carolina. Two members shall be appointed by the Governor to represent the interest of the public at large. These two members shall be neither licensed speech and language pathologists nor audiologists. These members shall be appointed not later than July 1, 1981; one shall be initially appointed for a term of two years; the other shall be appointed for a term of three years. Thereafter all public members shall serve three-year terms."

SECTION 6. G.S. 90-304(a)(3) reads as rewritten:

"(a) The powers and duties of the Board are as follows:

...

(3) To adopt responsible rules ~~and regulations~~including ~~but not limited to regulations which~~rules that establish ethical standards of practice and require continuing professional education and to amend or repeal the same."

SECTION 7. Section 4 of this act becomes effective October 1, 2007. The remaining sections are effective when this act becomes law.

HOUSE BILL 892:
Update Licensure Act/Speech Pathologists

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 17, 2007
Introduced by:	Rep. Faison	**Summary by:**	Shawn Parker
Version:	PCS to Third Edition H892-CSSQ-46		Legislative Analyst

SUMMARY: House Bill 892 would amend a series of provisions in the Licensure Act for Speech and Language Pathologist and Audiologists (Article 22 of Chapter 90 of the General Statutes). The bill would update the terminology contained in several definitions in the Act, would amend the provision addressing licensure as an audiologist, the provision relating to licensure as a pathologist, and the provision setting forth the powers and duties of the Board of Examiners for Speech and Language Pathologist and Audiologist regarding required continued education.

The Senate Proposed Committee Substitute exempts from the Article a licensed physical therapy practitioner providing evaluation and treatment within the context of their practice.

BILL ANALYSIS: Section 1 provides a speech language pathologist is a person that evaluates, examines, instructs, counsels or treats persons suffering from conditions or disorders affecting speech and language or swallowing. The section also amends the definition of habilitation and rehabilitation, for the purposes of the subdivision, to include aural rehabilitation.

Section 2 removes physicians, persons performing audiometric screenings under the supervision of a physician, and laryngectomee counselors from person to which the provisions of the Article do no apply.

Section 3 (a) provides the Article does not apply to a person employed by a physician licensed to practice medicine nor the physician providing services in the course of the physician's practice of medicine, **(b)** provides the Article does not apply to licensed occupational therapy practitioners or ***licensed physical therapy practitioners*** providing services within the context of occupational therapy practice.

Section 4 effective October 1, 2007, increases the number of qualified credit hours that must be completed to 75 (was 60) and increases the number of clock hours of supervised, direct clinical experience to 400 (was 300) for an applicant for permanent licensure as a speech and language pathologist.

Also effective October 1, 2007, to be eligible for permanent licensure as an audiologist the applicant must: possess a doctoral degree in audiology or equivalent qualifications from an accredited institution; present evidence of the completion of 90 semester hours constituting a well-integrated program course of study; present written evidence of 1,800 clock hours of professional experience directly supervised by an authorized audiologist; pass an exam established or approved by the Board.

Section 5 makes conforming changes to apply to Board membership.

Section 6 directs the Board to adopt rules to require continuing professional education.

EFFECTIVE DATE: Section 4 of this act is effective October 1, 2007, the remaining sections are effective when the act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 892

Committee Substitute Favorable 5/21/07
Committee Substitute #2 Favorable 5/29/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H892-PCS60385-SQ-46

Short Title: Update Licensure Act/Speech Pathologists. (Public)

Sponsors:

Referred to:

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE LICENSURE ACT FOR SPEECH AND LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-293 reads as rewritten:

"**§ 90-293. Definitions.**

As used in this Article, unless the context otherwise requires:

(1) "Audiologist" means any person who engages in the practice of audiology. A person is deemed to be an audiologist if he offers services to the public under any title incorporating the terms of "audiology," "audiologist," "audiological," "hearing clinic," "hearing clinician," "hearing therapist," or any similar title or description of service.

(2) "Board" means the Board of Examiners for Speech and Language Pathologists and Audiologists.

(3) "License" means a license issued by the Board under the provisions of this Article, including a temporary license.

(4) "Person" means an individual, organization, or corporate body, except that only individuals can be licensed under this Article.

(5) "Speech and language pathologist" means any person who represents himself or herself to the public by title or by description of services, methods, or procedures as one who evaluates, examines, instructs, ~~or counsels~~counsels, or treats persons suffering from conditions or disorders affecting speech and ~~language.~~language or swallowing. A person is deemed to be a speech and language pathologist if ~~he~~ the person offers such services under any title incorporating the words

"speech pathology," "speech pathologist," "speech correction," "speech correctionist," "speech therapy," "speech therapist," "speech clinic," "speech clinician," "language pathologist," "language therapist," "logopedist," "communication disorders," "communicologist," "voice therapist," "voice pathologist," or any similar title or description of service.

(6) "The practice of audiology" means the application of principles, methods, and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to ~~hearing and disorders of~~ hearing and vestibular disorders for the purpose of identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals ~~and/or~~or groups of individuals. For the purpose of this subdivision, the words "habilitation" and "rehabilitation" shall include auditory training, speech reading, aural rehabilitation, hearing aid use evaluation and recommendations, and fabrication of earmolds and similar accessories for clinical testing ~~purposes only.~~purposes.

(7) "The practice of speech and language pathology" means the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, ~~counseling,~~counseling, treating, instruction, habilitation, or rehabilitation related to the development and disorders of speech, voice, ~~or language~~language, and swallowing for the purpose of identifying, preventing, ameliorating, or modifying such disorders.

(8) Repealed by Session Laws 1987, c. 665, s. 1.

(9) "Accredited college or university" means an institution of higher learning accredited by the Southern Association of Colleges and Universities, or accredited by a similarly recognized association of another locale."

SECTION 2. G.S. 90-294(c) reads as rewritten:

"(c) The provisions of this Article do not apply to:

(1) The activities, services and use of an official title by a person employed by an agency of the federal government and solely in connection with such employment.

(2) The activities and services of a student or trainee in speech and language pathology or audiology pursuing a course of study in an accredited college or university, or working in a training center program approved by the Board, if these activities and services constitute a part of such person's course of study.

(3) Repealed by Session Laws 1987, c. 665, s. 2.

(4) A person who holds a valid and current credential as a speech and language pathologist or audiologist issued by the North Carolina Department of Public Instruction or who is employed by the North Carolina Schools for the Deaf and Blind, if such person practices

speech and language pathology or audiology in a salaried position solely within the confines or under the jurisdiction of the Department of Public Instruction or the Department of Health and Human Services respectively.

~~(5) A physician licensed to practice medicine.~~

~~(6) Persons performing audiometric screenings and whose work is under the supervision of a licensed physician, or licensed audiologist.~~

~~(7) Persons who are now or may become engaged in counseling or instructing laryngectomees in the methods, techniques, or problems of learning to speak again.~~"

SECTION 3.(a) G.S. 90-294(d) reads as rewritten:

"(d) Nothing in this Article shall apply to a physician licensed to practice medicine, or to any person employed by ~~such~~ a physician licensed to practice medicine in the course of ~~his~~ the physician's practice of medicine."

SECTION 3.(b) G.S. 90-294 is amended by adding a new subsection to read:

"(i) Nothing in this Article shall apply to a licensed physical therapy or occupational therapy practitioner providing evaluation and treatment of swallowing disorders, cognitive/communication deficits, and balance functions within the context of his or her licensed practice."

SECTION 4. G.S. 90-295 reads as rewritten:

"**§ 90-295. Qualifications of applicants for permanent licensure.**

(a) To be eligible for permanent licensure by the Board as a speech and language ~~pathologist or audiologist,~~pathologist, the applicant must:

(1) Possess at least a master's degree in speech and language pathology ~~or audiology~~ or qualifications deemed equivalent by the Board under ~~regulations~~ rules duly adopted by the Board under this Article. ~~Such~~ The degree or equivalent qualifications shall be from an accredited institution.

(2) Submit transcripts from one or more accredited colleges or universities presenting evidence of the completion of ~~60~~ 75 semester hours constituting a well-integrated program of course study dealing with the normal aspects of human communication, development thereof, disorders thereof, and clinical techniques for evaluation and management of such disorders.

a. ~~Twelve~~ Fifteen of these ~~60~~ 75 semester hours must be obtained in courses that provide information that pertains to normal development and use of speech, language and hearing.

b. ~~Thirty~~ Thirty-six of these ~~60~~ 75 semester hours must be in courses that provide information relative to communication disorders and information about and training in evaluation and management of speech, language, and hearing disorders. At least 24 of these 30 semester hours must be in courses in ~~the professional area (speech and language pathology or audiology)~~

~~for which the license is requested, and no less than six semester hours may be in audiology for the license in speech and language pathology or in speech and language pathology for the license in audiology. Moreover, no more than six semester hours may be in courses that provide credit for clinical practice obtained during academic training.~~speech and language pathology.

c. Credit for study of information pertaining to related fields that augment the work of the clinical practitioner of speech and language pathology ~~and/or~~or audiology may also apply toward the total ~~60~~75 semester hours.

d. ~~Thirty~~Thirty-six of the total ~~60~~75 semester hours that are required for a license must be in courses that are acceptable toward a graduate degree by the college or university ~~in~~at which they are taken. Moreover, 21 of those ~~30 semester hours must be within the 24 semester hours required in the professional area (speech and language pathology or audiology) for which the license is requested or within the six semester hours required in the other area.~~semester hours must be in graduate level courses in speech and language pathology.

(3) Submit evidence of the completion of a minimum of ~~300~~400 clock hours of supervised, direct clinical experience with individuals who present a variety of communication disorders. This experience must have been obtained within the training institution or in one of its cooperating ~~programs.~~programs in the following areas: (i) Speech – Adult (200 diagnostic and 200 therapeutic); Children (200 diagnostic and 200 therapeutic); or (ii) Language – Adult (200 diagnostic and 200 therapeutic); Children (200 diagnostic and 200 therapeutic). Each new applicant must submit a verified clinical clock hour summary sheet signed by the clinic or program director, in addition to completion of the license application.

(4) Present written evidence ~~from a licensed and/or American Speech and Hearing Association certified speech and language pathologist or audiologist supervisor of nine months of full-time professional experience in which bona fide clinical work has been accomplished in the major professional area (speech and language pathology or audiology) in which the license is being sought.~~ of nine months of full-time professional experience in which bona fide clinical work has been accomplished in speech and language pathology. The professional work must have been supervised by a speech and language pathologist who is State-licensed or certified by the American Speech-Language-Hearing Association. This experience must follow the completion of the requirements listed in subdivisions (1), (2) and (3). Full time is defined as at least nine months in a

calendar year and a minimum of 30 hours per week. Half time is defined as at least 18 months in two calendar years and a minimum of 20 hours per week. The supervision must be performed by a person who holds a valid license under this Article, or certificate of clinical competence from the American Speech-Language-Hearing Association, in ~~the specific area for which licensure is sought.~~speech and language pathology.

(5) Pass an examination established or approved by the Board.

(b) To be eligible for permanent licensure by the Board as an audiologist, the applicant must:

(1) Possess a doctoral degree in audiology or qualifications deemed equivalent by the Board under rules duly adopted by the Board under this Article. The degree or equivalent qualifications shall be from an accredited institution.

(2) Persons who were engaged in the practice of audiology and do not possess a doctoral degree in audiology before October 1, 2007, shall be exempt from the degree requirement in subdivision (1) of this subsection provided those persons remain continuously licensed in the field.

(3) Submit transcripts from one or more accredited colleges or universities presenting evidence of the completion of 90 semester hours constituting a well-integrated program of course study dealing with the normal aspects of human communication, the development of human communication, the disorders associated with human communication, and the clinical techniques for evaluation and management of such disorders.

(4) Present written evidence documenting 1,800 clock hours of professional experience directly supervised by an audiologist who is State-licensed or certified by the American Speech-Language-Hearing Association or other Board-approved agency. The clock hours of professional experience must be with individuals who present a variety of communication and auditory disorders and must have been obtained within the training program at an accredited college or university or in one of its cooperating programs.

(5) Pass an examination established or approved by the Board."

SECTION 5. G.S. 90-303(a) reads as rewritten:

"(a) There shall be a Board of Examiners for Speech and Language Pathologists and Audiologists, which shall be composed of seven members, who shall all be residents of this State. Two members shall have a paid work experience in audiology for at least five years and hold a ~~certificate of clinical competence in audiology of the American Speech and Hearing Association.~~North Carolina license as an audiologist. Two members shall have paid work experience in speech pathology for at least five years and hold a ~~certificate of clinical competence in speech pathology of the American Speech and Hearing Association.~~North Carolina license as a speech and language

pathologist. One member shall be a physician who is licensed to practice medicine in the State of North Carolina. Two members shall be appointed by the Governor to represent the interest of the public at large. These two members shall be neither licensed speech and language pathologists nor audiologists. These members shall be appointed not later than July 1, 1981; one shall be initially appointed for a term of two years; the other shall be appointed for a term of three years. Thereafter all public members shall serve three-year terms."

SECTION 6. G.S. 90-304(a)(3) reads as rewritten:

"(a) The powers and duties of the Board are as follows:

...

(3) To adopt responsible rules ~~and regulations~~including ~~but not limited to regulations which~~rules that establish ethical standards of practice and require continuing professional education and to amend or repeal the same."

SECTION 7. Section 4 of this act becomes effective October 1, 2007. The remaining sections are effective when this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 118

Committee Substitute Favorable 4/11/07

Short Title: Sex Offenders/Test for STDs. (Public)

Sponsors:

Referred to:

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A PERSON CHARGED WITH A SEX OFFENSE WHO IS ORDERED TO BE TESTED FOR A SEXUALLY TRANSMITTED INFECTION MUST BE TESTED WITHIN FORTY-EIGHT HOURS OF THE COURT ORDER AND TO PROVIDE THAT HIV TESTING UNDER THESE PROVISIONS WILL USE THE VIRAL LOAD DETECTION METHOD OF DETERMINING HIV INFECTION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 15A-615(b) reads as rewritten:

"(b) Upon a request under subsection (a) of this section, the district attorney shall petition the court on behalf of the victim for an order requiring the defendant to be tested. Upon finding that there is probable cause to believe that the alleged sexual contact involved in the offense would pose a significant risk of transmission of a sexually transmitted infection listed in subsection (a) of this section, the court shall order the defendant to submit to testing for these infections. A defendant ordered to be tested under this section shall be tested not later than 48 hours after the date of the court order. A test for HIV ordered pursuant to this section shall use the viral load detection method of determining HIV infection."

SECTION 2. This act becomes effective December 1, 2007, and applies to offenses committed on or after that date.

HOUSE BILL 118:
Sex Offenders/Test for STDs

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 16, 2007
Introduced by:	Reps. Goforth, Ray, Glazier, Spear	**Summary by:**	Ben Popkin
Version:	Second Edition		Committee Counsel

SUMMARY: House Bill 118 would provide that a defendant who is under court order to be tested for a sexually transmitted disease be tested no later than 48 hours after the date of the court order. House Bill 118 would also specify that a test for HIV ordered under G.S. 15A-615 must use the "viral load detection method" of determining HIV infection.

CURRENT LAW: G.S. 15A-615 (Testing of certain persons for sexually transmitted infections) provides that after a finding of probable cause or an indictment that involves certain sexual offenses, the victim or the parent, guardian, or guardian ad litem of a minor victim may request that a defendant be tested for chlamydia, gonorrhea, hepatitis B, herpes, HIV, and syphilis. If the court finds that there is probable cause to believe that the alleged sexual contact would pose a significant risk of transmission of one of these sexually transmitted infections, the court must order the defendant to submit to testing for the infections. If the defendant is in the custody of the Department of Correction, the defendant will be tested by the Department of Correction. If the defendant is not in the custody of the Department of Correction, the defendant will be tested by the local health department.

Under current law, there is no statutorily required time by which a defendant must receive a court ordered test for sexually transmitted infections.

BILL ANALYSIS: House Bill 118 would provide that a defendant who is under court order to be tested for a sexually transmitted disease be tested no later than 48 hours after the date of the court order. House Bill 118 would require that a test for HIV ordered under G.S. 15A-615 must use the "viral load detection method" of determining HIV infection.

EFFECTIVE DATE: House Bill 118 would become effective December 1, 2007 and would apply to offenses committed on or after that date.

Jeff Hudson, counsel to House Judiciary II, substantially contributed to this summary.

H0118e2-SMRD

§ 15A-615. Testing of certain persons for sexually transmitted infections.

(a) After a finding of probable cause pursuant to the provisions of Article 30 of Chapter 15A of the General Statutes or indictment for an offense that involves nonconsensual vaginal, anal, or oral intercourse; an offense that involves vaginal, anal, or oral intercourse with a child 12 years old or less; or an offense under G.S. 14-202.1 that involves vaginal, anal, or oral intercourse with a child less than 16 years old; the victim or the parent, guardian, or guardian ad litem of a minor victim may request that a defendant be tested for the following sexually transmitted infections:

(1) Chlamydia;
(2) Gonorrhea;
(3) Hepatitis B;
(3a) Herpes;
(4) HIV; and
(5) Syphilis.

In the case of herpes, the defendant, pursuant to the provisions of this section, shall be examined for oral and genital herpetic lesions and, if a suggestive but nondiagnostic lesion is present, a culture for herpes shall be performed.

(b) Upon a request under subsection (a) of this section, the district attorney shall petition the court on behalf of the victim for an order requiring the defendant to be tested. Upon finding that there is probable cause to believe that the alleged sexual contact involved in the offense would pose a significant risk of transmission of a sexually transmitted infection listed in subsection (a) of this section, the court shall order the defendant to submit to testing for these infections.

(c) If the defendant is in the custody of the Department of Correction, the defendant shall be tested by the Department of Correction. If the defendant is not in the custody of the Department of Correction, the defendant shall be tested by the local health department. The Department of Correction shall inform the local health director of all test results. The local health director shall ensure that the victim is informed of the results of the tests and counseled appropriately. The agency conducting the tests shall inform the defendant of the results of the tests and ensure that the defendant is counseled appropriately. The results of the tests shall not be admissible as evidence in any criminal proceeding.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 118

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

H118-ASQ-26 [v.1]

Date 7/18 ,2007

Comm. Sub. [NO]
Amends Title [YES]
Second Edition

~~Representative~~ Purcell

moves to amend the bill on page 1, lines 6-7, by rewriting the lines to read:
" PROVISIONS WILL USE THE HIV-RNA DETECTION TEST FOR DETERMINING HIV INFECTION.";

And on page 1, lines 17-18, by rewriting the lines to read:
"order. A test for HIV ordered pursuant to this section shall use the HIV-RNA Detection Test for determining HIV infection.".

SIGNED Purcell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 118

Committee Substitute Favorable 4/11/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H118-PCS70590-SQ-56

Short Title: Sex Offenders/Test for STDs. (Public)

Sponsors:

Referred to:

February 8, 2007

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A PERSON CHARGED WITH A SEX OFFENSE WHO IS ORDERED TO BE TESTED FOR A SEXUALLY TRANSMITTED INFECTION MUST BE TESTED WITHIN FORTY-EIGHT HOURS OF THE COURT ORDER AND TO PROVIDE THAT HIV TESTING UNDER THESE PROVISIONS WILL USE THE HIV-RNA DETECTION TEST FOR DETERMINING HIV INFECTION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 15A-615(b) reads as rewritten:

"(b) Upon a request under subsection (a) of this section, the district attorney shall petition the court on behalf of the victim for an order requiring the defendant to be tested. Upon finding that there is probable cause to believe that the alleged sexual contact involved in the offense would pose a significant risk of transmission of a sexually transmitted infection listed in subsection (a) of this section, the court shall order the defendant to submit to testing for these infections. A defendant ordered to be tested under this section shall be tested not later than 48 hours after the date of the court order. A test for HIV ordered pursuant to this section shall use the HIV-RNA Detection Test for determining HIV infection."

SECTION 2. This act becomes effective December 1, 2007, and applies to offenses committed on or after that date.

VISITOR REGISTRATION SHEET

Senate Health Care — **July 18, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dirk Carlton	attorney at Law
Sue Lhadfield	Nurse
Lew Borman	BCBSNC
Michelle Gaskins	BCBSNC
Angie Caley	DHHS Division Health Services Regulation
Sheria Reid	The Daily Bulletin (DOG)
Sarah Preston	ACLU-NC
Sara Schmidt	Action for Children NC
[illegible]	NCPTA & NCDS
Adam S. Keith	NCGA Staff
Jeff Emery	NCGA

VISITOR REGISTRATION SHEET

Senate Health Care — **July 18, 2007**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Cline	DHHS - DPH
David Holbrook	N.C. Board of Nursing
Deno Adkins	Moses Cone Health System (CNCHA)
Joan Sleven	Nursing
John Bowdich	AstraZeneca
Barbara Canales	PSCA
Tim Byler	Novartis
Steve Mitchell	Astellas Pharma
Jeff Myers	

VISITOR REGISTRATION SHEET

Senate Health Care — **July 18, 2007**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCFDC
	AHCS
	BCA
Sarah Price	BCA
KBlatt	UNC-TC

CORRECTED NOTICE: HB1738, SB915 ADDED

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	July 25, 2007	11:00 AM	544

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 627	Extend Pilot/Clarify LME Functions/LME Admin.	Representative Insko
HB 628	Uniform Sliding Fees - MH/DD/SA Services.	Representative Insko
HB 818	Amend Practice of Medicine Laws.-AB	Representative Allen
HB 1577	Amend Hearing Aid Dealers/Fitters Laws/Fees.	Representative England, M.D.
HB 1738	Advisory Comm./Hosp. Infection Incidence.	Representative Allen Representative Alexander Representative Glazier Representative Insko
SB 915	Assisted Living Facility Amendments.	Senator Nesbitt, Jr.

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

SENATE HEALTH CARE COMMITTEE
Wednesday, July 25, 2007
11:00 A.M.
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 11, 2007, in Room 544 of the Legislative Office Building, with sixteen members present, and Senator William R. Purcell presiding. Senator Purcell welcomed the committee members present, and introduced the pages and sergeants-at-arms.

Senator Purcell asked Representative Glazier to present HB1738, *Advisory Comm./Hosp.Infection Incidence.* Senator Atwater moved to adopt a proposed committee substitute. Senator Bingham moved for a favorable report as to the PCS, unfavorable as to the bill, and the bill was re-referred to the Appropriations Committee.

Representative Allen spoke to HB818, *Amend Practice of Medicine Laws-AB.* A PCS for this bill was reviewed for the committee by Mr. Popkin and voted on for purposes of discussion. Senator Bingham proposed an amendment to rewriting line 43 and renumbering the following sections. Senator Nesbitt suggested that if the recommendations for appointment made by the Medical Board are not chosen by the Governor, the Review Panel should recommend at least two new qualified nominees. This suggestion was put into an amendment and accepted by the Committee. Senator Foriest asked how this information will be disseminated, and the Chair recognized Mr. Thom Mansfield, legislative counsel for the Medical Board. He replied that the bill provides that all licensees will be notified in a timely manner. After additional discussion Senator moved for a favorable report, favorable as to the PCS with the two amendments rolled into it, unfavorable as to the original bill.

Representative Insko presented HB628, *Uniform Sliding Fees – MH/DD/SA/LME Admin.* A PCS for this bill was voted on. After some discussion regarding the poverty level, Senator Bingham moved for a favorable report as to the PCS, unfavorable as to the original bill. The bill was re-referred to the Finance Committee.

Senator Purcell asked Representative Insko to explain HB627, *Extend Pilot/Clarify LME Functions/LME Admin.* This bill also had a PCS, which was voted on. Senator Kinnaird asked about master psychology practitioners doing screening, but not listed in the bill. The question was referred to Ms. Lisa Wainwright of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services responded that the pilot program has not had sufficient data to justify using these, but this certainly would be kept in mind as data comes in. Senator Bingham moved for a favorable report as to the PCS, unfavorable as to the original bill.

Senator England brought up HB1577, *Amend Hearing Aid Dealers/Fitters Laws/Fees.* Senator Forrester moved for a favorable report. The bill was referred to the Finance Committee.

Senator Nesbitt explained his bill, SB915, *Assisted Living Facility Amendments.* A PCS was adopted. He asked Mr. Parker to make a brief explanation of the PCS. Senator Hartsell moved for a favorable report as to the PCS, unfavorable as to the bill.

The meeting adjourned at 12:03 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 25, 2007

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

FAVORABLE

H.B. **1577** Amend Hearing Aid Dealers/Fitters Laws/Fees.
Sequential Referral: Finance
Recommended Referral: None

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

H.B. **1738** Advisory Comm./Hosp. Infection Incidence.
Draft Number: 30520
Sequential Referral: Appropriations/Base Budget
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) **627** Extend Pilot/Clarify LME Functions/LME Admin.
Draft Number: 70603
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **628** Uniform Sliding Fees - MH/DD/SA Services.
Draft Number: 80482
Sequential Referral: None
Recommended Referral: Finance
Long Title Amended: Yes

TOTAL REPORTED: 4

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, July 26, 2007

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

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

S.B. **915** Assisted Living Facility Amendments.

Draft Number:	55550
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 3, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #3) **818** Amend Practice of Medicine Laws.-AB

Draft Number:	50758
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

D

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 818 – DATE _____

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

COMMITTEE SUBSTITUTE H818 - CSSQ - 61[v. 3]

Rep.)
Sen.) Bingham

moves to amend the bill on page 7, line 27

( ) WHICH CHANGES THE TITLE

by deleting the line;

and on page 9, by rewriting line 43 to read:

"SECTION 13. G.S. 90-12 is repealed."

and by renumbering the remaining Sections accordingly.

SIGNED Stan Bingham

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 818 DATE _____

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

COMMITTEE SUBSTITUTE _____

Rep.) Nesbitt
Sen.)

moves to amend the bill on page 5, line 21

( ) WHICH CHANGES THE TITLE

by inserting the following after the period:

"If the Governor choses not to appoint either of the ~~team~~ recommended nominees, the Review Panel shall recommend at least two new qualified nominees."

SIGNED Martin Nesbitt

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 627*

Committee Substitute Favorable 5/17/07

Short Title: Extend Pilot/Clarify LME Functions/LME Admin. (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE FIRST COMMITMENT PILOT PROGRAM, TO FURTHER CLARIFY LME CORE FUNCTIONS, AND TO ALLOW ADDITIONAL TIME FOR AN LME TO MERGE WHEN IT HAS GONE BELOW THE TWO HUNDRED THOUSAND POPULATION OR SIX COUNTY THRESHOLD DUE TO A CHANGE IN COUNTY MEMBERSHIP AS RECOMMENDED BY THE JOINT LEGISLATIVE COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES; AND TO ALLOW AREA AUTHORITIES WITH EIGHT OR MORE COUNTIES TO HAVE UP TO THIRTY MEMBERS ON THE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1.(a) S.L. 2003-178, as amended by S.L. 2006-66, Section 10.27, reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of ~~a phase-one local management entity~~an LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from ~~a phase-one local management entity~~an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the ~~local management entity~~LME shall ~~be submitted as part of the entity's local business plan and shall~~ specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.
b. How the waiver will enable the ~~local management entity~~LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.
c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.
d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:
a. The request meets the requirements of this section.
b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.
c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.
d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services ~~on or before July 1, 2006.~~ by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until October 1, ~~2007.~~2010.

(5) The Secretary may grant a waiver under this section to up to ~~five~~ 10 ~~local management entities that have been designated as phase one entities as of July 1, 2003.~~LMEs.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the

licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The ~~local management entity~~LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires October 1, ~~2007.~~2010."

SECTION 1.(b) The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall review the report submitted by the Secretary under Section 1(a) of this act. The LOC shall make recommendations to the 2010 Regular Session of the 2009 General Assembly regarding whether to extend the pilot, discontinue the pilot, or make the provisions of the pilot permanent and statewide.

SECTION 2. G.S. 122C-115.4 reads as rewritten:

"**§ 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 are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions 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.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions.

(c) Subject to subsection (b) of this section and all applicable State and federal laws and rules established by the Secretary, an ~~area authority, or county program or consolidated human services agency~~ LME may contract with a public or private entity for the implementation of LME functions ~~articulated~~ designated 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 or designate another entity as also eligible to implement 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 3. G.S. 122C-115(a1) reads as rewritten:

"(a1) Effective July 1, 2007, ~~The~~ the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for ~~area authorities and county programs~~ LMEs that do not comply with the catchment area requirements of ~~this section.~~subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section."

SECTION 4. 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, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial 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. "

SECTION 5. Section 3 of this act becomes effective July 1, 2007. The remainder of this act is effective when it becomes law.

HOUSE BILL 627:
Extend Pilot/Clarify LME Functions/LME Admin

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 25, 2007
Introduced by:	Rep. Insko	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to Second Edition H627-CSRC-63		

SUMMARY: The Proposed Committee Substitute to House Bill 627 incorporates many of the provisions of 3 House Bills. The PCS would:

- *Extend a pilot program that allows certain Master's level professionals to conduct the initial examination of a person to determine whether the person is a threat to themselves or others.*
- *Clarify that Local Management Entity (LME) administrative functions may only be implemented by an LME unless the LME contracts with a third party.*
- *Provide more specificity regarding the LME function of care coordination and quality management.*
- *Hold harmless for one year an LME that falls below the catchment area requirements due to a loss of counties.*
- *Allow an LME with eight or more counties to have a governing board of up to 30 members.*
- *Prohibit an individual who contracts with an LME for the delivery of services from being a board member during the term of the contract.*
- *Require the Secretary of the Department of Health and Human Services (DHHS) to develop a model LME business plan.*
- *Directs the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission) to adopt rules related to the uniform portal process, the monitoring and endorsement of providers, and the provision of technical assistance by LMEs to providers.*
- *Requires that any waiver issued by the Secretary allowing an LME to provide services shall be for at least 1 year, unless the LME requests a shorter waiver.*
- *Adds two attorneys to the appointments by the General Assembly to the Commission.*
- *Directs the Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to study whether the rule making authority for the Secretary and the Commission should be modified to eliminate any duplication, conflict, or lack of clarity.*

CURRENT LAW:

Involuntary Commitment - The process for inpatient involuntary commitment requires a number of steps, but the fundamental question is whether a person is *mentally ill and a threat to himself or others.* Anyone who has knowledge of an individual who meets these criteria may appear before a magistrate or

clerk and execute an Affidavit and Petition for Involuntary Commitment. If the magistrate or clerk finds reasonable grounds to believe the facts alleged in the affidavit, the magistrate or clerk must issue and order for law enforcement to take the respondent (person who is the subject to the petition) into custody for an examination by a physician or eligible psychologist. A physician is an individual licensed to practice medicine under Chapter 90 of the General Statutes. An eligible psychologist means a licensed psychologist who holds permanent licensure and certifications as a health services provider psychologist issued by North Carolina Psychology Board, i.e., a PhD level psychologist.

This is the first examination in the commitment process. Depending upon the results of this examination, the respondent may or may not be released within 24 hours and the process may or may not result in the respondent being transported to a 24 hour facility and examined a second time. The first examination must occur within 24 hours after the respondent is presented for examination. The examination must include all of the following:

- Current and previous mental illness and, if available, previous treatment history
- Dangerousness to himself or others
- Ability to survive safely without inpatient commitment, including the availability of supervision by family, friends or others
- Capacity to make an informed decision concerning treatment.

In 2003, the General Assembly passed legislation (S.L. 2003-178) which has been referred to as the "First Commitment Pilot Program". The legislation allowed the Secretary to approve LME requests to substitute appropriately trained licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct first-level examinations. Under the Pilot Program, the Secretary could grant waivers to up to five LMEs for periods of time not to exceed three years and required that participating LMEs, "...assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary." The Secretary approved the following five LMEs to participate in the pilot program: CenterPoint Human Services, Crossroads Behavioral Healthcare, Pathways MH/DD/SAS, Smoky Mountain Center, and Piedmont Behavioral Healthcare.

LME Administrative Functions - During the 2006 Session, the General Assembly enacted G.S. 122C-115.4 which specifies the administrative functions of an LME. Those functions are: (1) access to the core services of screening, assessment, referral (STR), emergency services, education, prevention, and service coordination; (2) provider endorsement and quality control; (3) utilization management and review for State-paid consumers; (4) authorization of services for State facilities; (5) care coordination; (6) community collaboration; and (7) financial management. These same functions are reflected in the local business plan that each LME must develop and submit to the Secretary for approval.[1]

The legislation was recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC). The LOC made the recommendation in response to a number of proposals by the Secretary and the Department. These included regionalizing after hours STR and utilization management for Medicaid consumers.

Funding for LME Administrative Functions - In order to achieve additional LME consolidations, the General Assembly adopted legislation in 2006 that requires the Division of MH/DD/SA to reduce by

[1] G.S. 122C-115.2.

10% the administrative funds provided to an LME that contains fewer than 6 counties or fewer than 200,000 population in its catchment area as of July 1, 2007.

LME Board Structure – LMEs may have as few as 11 members and as many as 25. However, if the LME has 8 or more counties and a catchment area population of at least 500,000, then the board may have up to 30 members.

Conflicts of Interest for LME Board members – G.S. 14-234 prohibits members of local governing boards from participating discussions or voting on contracts between the public body and a company the member owns or has financial ties to.

Rule Making Authority - The Commission for Mental Health, Developmental Disabilities and Substance Abuse Services ("Commission") is created under Part 4 of Article 3 (regarding the Department of Health and Human Services) of Chapter 143B of the General Statutes. The Commission has broad rule making authority regarding "State and local mental health, developmental disabilities, substance abuse programs including education, prevention, intervention, screening, assessment, referral, detoxification, treatment, rehabilitation, continuing care, emergency services, case management, and other related services."[2] The Commission is also authorized to adopt rules related to the licensing of MH/DD/SA facilities[3] as well as the professional staff qualifications for those facilities[4], the registration and control of controlled substances under G.S. 90-100[5], certain appeals processes[6], as well as certain matters related to the administrative functions of LMEs[7]. The Commission may also make declaratory rulings related to the licensure of MH/DD/SA facilities.[8]

The Commission is composed of 30 members. Six are appointed by the General Assembly (3 upon the recommendation of the Speaker of the House and 3 upon the recommendation of the President Pro Tempore of the Senate). 24 are appointed by the Governor. The members are chosen with respect to very specific qualifications or interests.[9] Members serve for three years, and may not serve more than 2 consecutive terms.

The Secretary of the Department of Health and Human Services ("Secretary") also has rule making authority under Chapter 122C.[10] The statutory process for adopting a permanent rule is the same for both the Secretary and the Commission.[11] However, this process applies only after either the Secretary or the Commission has determined the particular content and wording to be published.

BILL ANALYSIS:

Section 1.1.(a) extends the First Commitment Pilot program to 5 additional LMEs for 3 more years.

Section 1.2 amends G.S. 122C-115.4 regarding the primary functions of an LME. It specifies that none of the listed functions may be conducted by another entity unless the LME voluntarily contracts with that entity to implement that function. It also provides specificity regarding what is intended by care

---

[2] G.S. 143B-147(a).
[3] Id. at (a)(2).
[4] Id. at (a)(6).
[5] Id. at (a)(5).
[6] Id. at (a)(9) and G.S. 122C-151.2.
[7] G.S. 122C-115.4(f)
[8] G.S. 122C-26(2).
[9] See excerpt of G.S. 143B-148(a)(1) and (a)(2) in the **BACKGROUND** portion of this summary.
[10] See G.S. 122C-112.1, 122C-125, and 122C-141(a).
[11] See attachment regarding process for adopting permanent rules. Administrative Office of the Courts.

coordination and quality management. This means the LME is involved in individual client care decisions in order to be sure the client is receiving the appropriate amount of effective treatment.

Section 1.3 amends G.S. 122C-115(a1) to provide that is an LME falls below the 6 county or 200,000 population minimum due to a loss of county membership, the LME shall have one year from the effective date of the loss to come into compliance with the catchment area requirements.

Section 1.4 amends G.S. 122C-118.1(a) to allow and LME that has eight or more counties to have a board of up to 30 members.

Sections 2.1 through 2.6 move certain rule making authority from the Secretary to the Commission and add 2 additional appointments by the General Assembly.

EFFECTIVE DATE: Many of the rule-making provisions become effective October 1, 2007. The remainder of the act is effective when it becomes law.

BACKGROUND:

First Commitment Pilot Program - In the Fall of 2006, the Department reported to the LOC on the pilot and recommended that it be made permanent and extended State wide. Because most of the data that was the basis for this recommendation came from one LME, the LOC decided to extend the pilot for three more years and add up to five more counties.

LME Administrative Functions - The purpose of STR is to gather basic demographic information about the consumer, determine whether the consumer is target or non-target population, make a very broad initial determination about the consumer's condition, and provide information regarding providers who can assist the consumer.

In the spring of 2006, the Division and LMEs negotiated a memorandum of agreement that outlined how STR should be handled. The MOA contemplated that only LMEs would implement STR for both Medicaid and non-Medicaid eligible consumers. The rational for this position was that LMEs needed to know who was entering the system and this was the most efficient way for them to have that information. LMEs were also concerned about "self-referral" by the providers conducting STR.

During the summer of 2006, DHHS took the position that private providers should be able to do STR for Medicaid eligible consumers. DHHS argued that this implemented the "no wrong door" policy of the system and that when a consumer walks in the door of a private provider, that consumer has already exercised his/her choice. LMEs objected to this position, arguing that there was no mechanism for LMEs to know when a Medicaid eligible consumer enters the system if the provider does STR. Eventually, DMH, DMA and the LMEs negotiated a system by which a provider must "register" a consumer with the LME within 5 days of the provider conducting STR. While some LMEs were satisfied with this solution, others have taken the position that the policy contradicts language adopted by the General Assembly in the 2006 session that lists STR as a "core function" of LMEs. Those LMEs also argue that the registration system is inefficient.

The Secretary has been under a statutory obligation since 2001 to adopt rules implementing a "uniform portal process". This term refers to how consumers enter and exit the public system. Who is authorized to conduct STR is directly related to the uniform portal process. The Secretary is currently in the process of adopting a rule regarding this matter. However, implementing the policy outlined above effectively circumvents the rule making process by keeping the policy in place until the rule becomes effective. DMA has also taken the position that federal law and regulations prohibit the State from placing limitation on which entities may conduct the STR function.

Funding for Administrative Functions – Foothills MH/DD/SA Area Authority requested this legislation. It has been comprised of 4 counties (Alexander, Burke, Caldwell and McDowell) with a catchment population of over 200,000. However, Burke County will probably merge with Catawba County, leaving the remaining 3 counties with a catchment area population of about 170,000. Based on the current legislation, Foothills would have experienced a 10% cut in its administrative funding, even though it has fallen below the thresholds through "out" mergers.

Board Membership – Smoky Mountain LME and New River LME will merge as of July 1, 2007. At that time, LME will have 12 counties, but will not meet the 500,000 population threshold. Smoky Mountain has requested that it also be allowed to have up to 30 board members.

H0627e2-SMRC-CSRC-63

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 627*

Committee Substitute Favorable 5/17/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H627-CSRC-63 [v.1]

Short Title: Extend Pilot/Clarify LME Functions/LME Admin. (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO AND STRENGTHEN THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES SYSTEM WITH RESPECT TO: THE FIRST COMMITMENT PILOT PROGRAM; LME FUNCTIONS, ADMINISTRATION, AND BOARD MEMBERSHIP; THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES RULE-MAKING AUTHORITY AND PROFESSIONAL STAFFING; THE QUALITY AND ACCESS OF MENTAL HEALTH SERVICES; AND REQUIREMENTS PERTAINING TO LME BUSINESS PLANS.

The General Assembly of North Carolina enacts:

SECTION 1.1.(a) S.L. 2003-178, as amended by S.L. 2006-66, Section 10.27, reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of ~~a phase-one local management entity~~an LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from ~~a phase-one local management entity~~an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request

from the ~~local management entity~~LME shall ~~be submitted as part of the entity's local business plan and shall~~ specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the ~~local management entity~~LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services ~~on or before July 1, 2006.~~ by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until October 1, ~~2007.~~2010.

(5) The Secretary may grant a waiver under this section to up to ~~five~~ 10 ~~local management entities that have been designated as phase one entities as of July 1, 2003.~~LMEs.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical

addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The ~~local management entity~~LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires October 1, ~~2007.~~2010."

SECTION 1.1.(b) The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall review the report submitted by the Secretary under Section 1.1.(a) of this act. The LOC shall make recommendations to the 2010 Regular Session of the 2009 General Assembly regarding whether to extend the pilot, discontinue the pilot, or make the provisions of the pilot permanent and statewide.

SECTION 1.2. G.S. 122C-115.4 reads as rewritten:

"**§ 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 are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions 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~~ criteria, fails to adequately document the provision of services, fails to provide required staff training, or fails to provide required data to the LME.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of ~~services~~ services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve ~~including the review and approval of the~~ person centered plans for consumers who receive State-funded ~~services. Concurrent review~~ services and shall conduct concurrent reviews 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.~~ involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.

b. Addressing difficult situations for clients or providers.

c. Consulting with providers regarding difficult or unusual care situations.

d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.

e. Coordinating client transitions from one service to another.

f. Conducting customer service interventions.

g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(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.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions.

(c) Subject to subsection (b) of this section and all applicable State and federal laws and rules established by the Secretary, an ~~area authority, or county program or consolidated human services agency~~ LME may contract with a public or private entity for the implementation of LME functions ~~articulated~~ designated under subsection (b) of this section.

(d) Except as provided in ~~G.S. 122C-142.1~~ G.S. 122C-124.1 and G.S. 122C-125, the Secretary may ~~not~~ neither remove from an LME nor designate another entity as eligible to implement 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 1.3. G.S. 122C-115(a1) reads as rewritten:

"(a1) Effective July 1, 2007, ~~The~~ the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for ~~area authorities and county programs~~ LMEs that do not comply with the catchment area requirements of ~~this section.~~subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section."

SECTION 1.4. G.S. 122C-118.1(a) and (b) read 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, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial 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) ~~Not~~ Except as otherwise provided in this subsection, 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) At least one family member or individual from a citizens' organization composed primarily of consumers or their family members, representing the interests of individuals:

a. With mental illness;

b. In recovery from addiction; or

c. With developmental disabilities.

(4) At least one openly declared consumer:

a. With mental illness;

b. With developmental disabilities; or

c. In recovery from addiction.

An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect."

SECTION 2.1. G.S. 122C-115.2(a) and (c) read as rewritten:

"**§ 122C-115.2. 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 an LME business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services. An LME business plan shall provide detailed information 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. The Secretary shall develop a model business plan that illustrates compliance with this section, including specific State standards and rules adopted by the Secretary. The Secretary shall provide each LME with the model business plan to assist the LME in developing its business plan.

(c) The county program or area authority proposing the business plan shall submit the proposed plan as approved by the board of county commissioners to the Secretary for review and certification. The Secretary shall review the business plan within 30 days of receipt of the plan. If the business plan meets all of the requirements of State law and standards adopted by the Secretary, then the Secretary shall certify the area authority or county program as a single-county area authority, a single-county program, a multicounty area authority, or a multicounty program. A business plan that demonstrates substantial compliance with the model business plan developed by the Secretary shall be deemed as meeting the requirements of State law and standards adopted by the Secretary. Implementation of the certified plan shall begin within 30

days of certification. If the Secretary determines that changes to the plan are necessary, then the Secretary shall so notify the submitting county program or area authority and the applicable participating boards of county commissioners and shall indicate in the notification the changes that need to be made in order for the proposed program to be certified. If the Secretary determines that a business plan needs substantial changes in order to be certifiable, the Secretary shall provide the LME submitting the plan with detailed information on each area of the plan that is in need of change, the particular State law or standard adopted by the Secretary that has not been met, and instructions or assistance on what changes need to be made in order for the plan to be certifiable. The submitting county program or area authority shall have 30 days from receipt of the Secretary's notice to make the requested changes and resubmit the amended plan to the Secretary for review. The Secretary shall provide whatever assistance is necessary to resolve outstanding issues. Amendments to the business plan shall be subject to the approval of the participating boards of county commissioners.

(d) Annually, in accordance with procedures established by the Secretary, each area authority and county program submitting a business plan shall enter into a memorandum of agreement with the Secretary for the purpose of ensuring that State funds are used in accordance with priorities expressed in the business plan."

SECTION 2.2. G.S. 122C-112.1(a)(14) reads as rewritten:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:

...

(14) ~~Adopt rules for the implementation of the uniform portal process.~~Implement the uniform portal process developed under rules adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services in accordance with G.S. 122C-114.

..."

SECTION 2.3. G.S. 122C-114 reads as rewritten:

"**§ 122C-114. Powers and duties of the Commission.**

(a) The Commission shall have authority as provided by this Chapter, Chapters 90 and 148 of the General Statutes, and by G.S. 143B-147.

(b) The Commission shall adopt rules regarding all of the following:

(1) The development of a process for screening, triage, and referral, including a uniform portal process, for implementation by the Secretary as required under G.S. 122C-112.1(14).

(2) LME monitoring and endorsement of providers of mental health, developmental disabilities, and substance abuse services.

(3) LME provision of technical assistance to providers of mental health, developmental disabilities, and substance abuse services.

(4) The requirements of a qualified public or private provider as that term is used in G.S. 122C-141. In adopting rules under this subsection, the Commission shall take into account the need to ensure fair competition among providers."

SECTION 2.4.(a) G.S. 122C-141 reads as rewritten:

"**§ 122C-141. Provision of services.**

(a) The area authority or county program shall contract with other qualified public or private providers, agencies, institutions, or resources for the provision of services, and, subject to the approval of the Secretary, is authorized to provide services directly. The area authority or county program shall indicate in its local business plan how services will be provided and how the provision of services will address issues of access, availability of qualified public or private providers, consumer choice, and fair competition. The Secretary shall take into account these issues when reviewing the local business plan and considering approval of the direct provision of services. Unless an area authority or county program requests a shorter time, any approval granted by the Secretary shall be for not less than one year. The Secretary shall develop criteria for the approval of direct service provision by area authorities and county programs in accordance with this section and as evidenced by compliance with the local business plan. For the purposes of this section, a qualified public or private provider is a provider that meets the provider qualifications as defined by rules adopted by the Secretary.

(b) All area authority or county program services provided directly or under contract shall meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. The Secretary may delay payments and, with written notification of cause, may reduce or deny payment of funds if an area authority or county program fails to meet these requirements.

(c) The area authority or board of county commissioners of a county program may contract with a health maintenance organization, certified and operating in accordance with the provisions of Article 67 of Chapter 58 of the General Statutes for the area authority or county program, to provide mental health, developmental disabilities, or substance abuse services to enrollees in a health care plan provided by the health maintenance organization. The terms of the contract must meet the requirements of all applicable State statutes and rules of the Commission and Secretary governing both the provision of services by an area authority or county program and the general and fiscal operation of an area authority or county program and the reimbursement rate for services rendered shall be based on the usual and customary charges paid by the health maintenance organization to similar providers. Any provision in conflict with a State statute or rule of the Commission or the Secretary shall be void; however, the presence of any void provision in that contract does not render void any other provision in that contract which is not in conflict with a State statute or rule of the Commission or the Secretary. Subject to approval by the Secretary and pending the timely reimbursement of the contractual charges, the area authority or county program may expend funds for costs which may be incurred by the area authority or county program as a result of providing the additional services under a contractual agreement with a health maintenance organization.

(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.~~Commission. 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.

(e) When enforcing rules adopted by the Commission, ~~The~~ 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 2.4.(b) The Department of Health and Human Services shall study the effect of G.S. 122C-141(d) 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 2.5.(a) G.S. 143B-148(a) reads as rewritten:

"**§ 143B-148. Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services – members; selection; quorum; compensation.**

(a) The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall consist of ~~30~~ 32 members, as follows:

(1) ~~Six~~ Eight shall be appointed by the General Assembly, ~~three~~ four upon the recommendation of the Speaker of the House of Representatives, and ~~three~~ four upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. In recommending appointments under this section, the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall give consideration to ensuring a balance of appointments that represent those who may have knowledge and expertise in adult issues and those who may have knowledge and expertise in children's issues. Of the ~~three~~ four appointments recommended by the President Pro Tempore of the Senate, one shall be an attorney licensed in this State with preference given to an attorney with experience in the practice of administrative law, one shall be a physician licensed to practice medicine in North Carolina, with preference given to a psychiatrist, and two shall be members of the public. Of the ~~three~~ four appointments recommended by the Speaker of the House of Representatives, one shall be an attorney licensed in this State with preference given to an attorney with experience in the practice of

mental health law, one shall be a physician licensed to practice medicine in North Carolina who has expertise and experience in the field of developmental disabilities, or a professional holding a Ph.D. with experience in the field of developmental disabilities, and two shall be members of the public. Vacancies in appointments made by the General Assembly shall be filled in accordance with G.S. 120-122.

(2) Twenty-four shall be appointed by the Governor, one from each congressional district in the State in accordance with G.S. 147-12(3)b, and the remainder at-large members.

The Governor's appointees shall represent the following categories of appointment:

a. Three professionals licensed or certified under Chapter 90 or Chapter 90B of the General Statutes who are practicing, teaching, or conducting research in the field of mental health.

b. Four consumers or immediate family members of consumers of mental health services. Of these four, at least one shall be a consumer and at least one shall be an immediate family member of a consumer. No more than two of the consumers or immediate family members shall be selected from nominations submitted by the Coalition 2001 or its successor organization.

c. Two professionals licensed or certified under Chapter 90 or Chapter 90B of the General Statutes who are practicing, teaching, or conducting research in the field of developmental disabilities, and one individual who is a "qualified professional" as that term is defined in G.S. 122C-3(31) who has experience in the field of developmental disabilities.

d. Four consumers or immediate family members of consumers of developmental disabilities services. Of these four, at least one shall be a consumer and at least one shall be an immediate family member of a consumer. No more than two of the consumers or immediate family members shall be selected from nominations submitted by the Coalition 2001 or its successor organization.

e. Two professionals licensed or certified under Chapter 90 of the General Statutes who are practicing, teaching, or conducting research in the field of substance abuse, and one professional who is a certified prevention specialist or who specializes in the area of addiction education.

f. An individual knowledgeable and experienced in the field of controlled substances regulation and enforcement. The controlled substances appointee shall be selected from recommendations made by the Attorney General of North Carolina.

g. A physician licensed to practice medicine in North Carolina who has expertise and experience in the field of substance abuse with preference given to a physician that is certified by the American Society of Addiction Medicine (ASAM).

h. Four consumers or immediate family members of consumers of substance abuse services. Of these four, at least one shall be a consumer and at least one shall be an immediate family member of a consumer. No more than two of the consumers or immediate family members shall be selected from nominations submitted by the Coalition 2001 or its successor organization.

i. ~~A licensed attorney.~~ An attorney licensed in this State. The appointments of professionals licensed or certified under Chapter 90 or Chapter 90B of the General Statutes made in accordance with this subdivision, and physicians appointed in accordance with subdivision (1) of this subsection shall be selected from nominations submitted to the appointing authority by the respective professional associations.

(2a) The terms of all Commission members ~~appointed or reappointed on or after July 1, 2002,~~ shall be three years. All Commission members shall serve their designated terms and until their successors are duly appointed and qualified. All Commission members may succeed themselves. A member appointed on and after July 1, 2002, shall not serve more than two consecutive terms.

(3) All appointments shall be made pursuant to current federal rules and regulations, when not inconsistent with State law, which prescribe the selection process and demographic characteristics as a necessary condition to the receipt of federal aid."

SECTION 2.5.(b) The appointments of licensed attorneys by the General Assembly in accordance with G.S. 143B-148(a), as amended by this act, shall be for initial terms of two years, and three-year terms thereafter.

SECTION 2.6. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall study the statutory rule-making authority of the Secretary of the Department of Health and Human Services and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. In conducting its study, the LOC shall determine whether there is duplication, conflict, or lack of clarity with respect to the Secretary's rule-making authority and that of the Commission. The LOC may also consider whether rule making should be more clearly divided between the Secretary and the Commission and, if so, how and for what reasons. The LOC shall report its findings and recommendations to the 2008 Regular Session of the 2007 General Assembly upon its convening.

SECTION 3. Sections 2.1 through 2.3 and Section 3 of this act become effective October 1, 2007. Sections 1.4 and 2.5 of this act apply to appointments made

on and after October 1, 2007. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 628*

Committee Substitute Favorable 3/26/07

Committee Substitute #2 Favorable 4/17/07

Short Title: Uniform Sliding Fees - MH/DD/SA Services. (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO CREATE A UNIFORM SLIDING FEE SCHEDULE FOR MH/DD/SA SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-146 reads as rewritten:

"**§ 122C-146. Fee for service.**

(a) The ~~area authority~~LME and its contractual provider agencies shall ~~prepare fee schedules~~ implement the standardized fee schedule and sliding fee schedule adopted by the Secretary ~~for services and~~ under G.S. 122C-112.1(a)(34). An LME that provides services and its contractual provider agencies shall also make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party ~~payment, except that individuals~~ payments. However, no individual may be refused services because of an inability to pay.

(b) Individuals may not be charged for free services, as required in "The Amendments to the Education of the Handicapped Act", P.L. 99-457, provided to eligible infants and toddlers and their families. This exemption from charges does not exempt insurers or other third-party payors from being charged for payment for these services, if the person who is legally responsible for any eligible infant or toddler is first advised that the person may or may not grant permission for the insurer or other payor to be billed for the free services. ~~However, no individual may be refused services because of an inability to pay.~~

(c) All funds collected from fees from ~~area authority~~LME operated services shall be used for the fiscal operation or capital improvements of the ~~area authority's~~LME's programs. The collection of fees by ~~an area authority~~an LME that provides services may not be used as justification for reduction or replacement of the budgeted commitment of

local tax revenue. All funds collected from fees by contractual provider agencies shall be used to provide services to individuals in targeted populations."

SECTION 2. G.S. 122C-112.1(a) is amended by adding a new subdivision to read:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:

...

(34) Adopt rules to implement a standard fee schedule and sliding fee schedule to be used by LMEs and by contractual provider agencies under G.S. 122C-146."

SECTION 3. The Secretary of the Department of Health and Human Services shall identify all services that are funded by or through the Department's budget and that do not require income-based criteria in order for an individual to be eligible to receive the service. The Secretary shall develop a proposal for implementing income-based criteria for eligibility for those programs and shall submit the proposal to the General Assembly and the Fiscal Research Division by November 1, 2007.

SECTION 4. Section 1 of this act becomes effective July 1, 2008, and applies to services provided on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 628:
Uniform Sliding Fees - MH/DD/SA Services

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 25, 2007
Introduced by:	Rep. Insko	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to Third Edition H628-PCS80478-LN-43		

SUMMARY: ***House Bill 628 would direct LMEs and private providers to implement a co-payment schedule based upon family income and rules adopted by the Secretary. The LME would be responsible for determining the co-payment for individuals who the LME authorizes to receive services. The Secretary is directed to adopt rules to implement a co-payment graduated schedule to be used by LMEs and private providers.***

The Proposed Committee Substitute differs from the original bill by denominating the funds collected as a co-payment rather than a fee, and by specifying an income limit for some consumers.

The bill should be re-referred to Senate Finance.

CURRENT LAW:

Local Management Entities (LMEs) and their contractual agencies are required to prepare fee schedules for services and make reasonable efforts to collect appropriate reimbursement for costs from individuals or entities based on an ability to pay.[1]

BILL ANALYSIS:

House Bill 628 directs LMEs and private providers to implement a co-payment schedule. The LME would be responsible for determining the co-payment for individuals authorized by the LME to receive services.

The Secretary must adopt rules implementing the co-payment schedule. Families whose income is 400% or greater than the federal poverty are eligible for services subject to the applicable co-pay.

EFFECTIVE DATE: This act becomes effective July 1, 2008, and applies to services provided on or after that date.

BACKGROUND:

A survey of LMEs by the Division during the fall of 2006 showed that there is no uniformity across the State regarding fee schedules. LMEs may or may not use the same fee schedule for all services. Some look at gross income, others do not. Some set an income floor below which no fee is charged, others do not. All LMEs that reported on their sliding fee scale had a maximum income above which no relief was provided. However, those maximum incomes ranged from $7,200 to $99,000 for a family of one. Two LMEs charged for "no shows", but the vast majority did not. Only one LME had a maximum monthly liability limit.[2]

H0628e3-SMRC-PCS80478-LN-43

[1] G.S. 122C-146

[2] Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services Report to the 2007 General Assembly

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 628*

Committee Substitute Favorable 3/26/07

Committee Substitute #2 Favorable 4/17/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H628-PCS80478-LN-43

Short Title: Uniform Graduated Co-paymt - MH/DD/SA Svces. (Public)

Sponsors:

Referred to:

March 14, 2007

A BILL TO BE ENTITLED

AN ACT TO CREATE A UNIFORM CO-PAYMENT SCHEDULE FOR MH/DD/SA SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-146 reads as rewritten:

"**§ 122C-146. ~~Fee for service.~~Uniform co-payment schedule.**

(a) The ~~area authority~~LME and its contractual provider agencies shall ~~prepare fee schedules~~ implement the co-payment schedule based on family income adopted by the Secretary ~~for services and~~ under G.S. 122C-112.1(a)(34). The LME is responsible for determining the applicability of the co-payment to individuals authorized by the LME to receive services. An LME that provides services and its contractual provider agencies shall also make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party ~~payment, except that individuals~~ payments. However, no individual may be refused services because of an inability to pay.

(b) Individuals may not be charged for free services, as required in "The Amendments to the Education of the Handicapped Act", P.L. 99-457, provided to eligible infants and toddlers and their families. This exemption from charges does not exempt insurers or other third-party payors from being charged for payment for these services, if the person who is legally responsible for any eligible infant or toddler is first advised that the person may or may not grant permission for the insurer or other payor to be billed for the free services. ~~However, no individual may be refused services because of an inability to pay.~~

(c) All funds collected from ~~fees from area authority~~co-payments for LME operated services shall be used ~~for the fiscal operation or capital improvements of the area authority's programs.~~to provide services to individuals in targeted populations.

The collection of ~~fees~~ co-payments by ~~an area authority~~ an LME that provides services may not be used as justification for reduction or replacement of the budgeted commitment of local tax revenue. All funds collected from co-payments by contractual provider agencies shall be used to provide services to individuals in targeted populations."

SECTION 2. G.S. 122C-112.1(a) is amended by adding a new subdivision to read:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:

...

(34) Adopt rules for the implementation of a co-payment graduated schedule to be used by LMEs and by contractual provider agencies under G.S. 122C-146. The co-payment graduated schedule shall be developed to require a co-payment for services identified by the Secretary. Families whose family income is four hundred percent (400%) or greater of the federal poverty level are eligible for services with the applicable co-payment."

SECTION 3. The Secretary of the Department of Health and Human Services shall identify all services that are funded by or through the Department's budget and that do not require income-based criteria in order for an individual to be eligible to receive the service. The Secretary shall develop a proposal for implementing income-based criteria for eligibility for those programs and shall submit the proposal to the General Assembly and the Fiscal Research Division by November 1, 2007.

SECTION 4. Section 1 of this act becomes effective July 1, 2008, and applies to services provided on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 818*

Committee Substitute Favorable 5/4/07
Committee Substitute #2 Favorable 5/14/07
Committee Substitute #3 Favorable 6/12/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H818-PCS50758-SQ-61

Short Title: Amend Practice of Medicine Laws.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF MEDICINE AND TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF DENTISTRY.

The General Assembly of North Carolina enacts:

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

"**§ 90-1A. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Medical Board.

(2) Hearing officer. – Any current or past member of the Board who is a physician, physician assistant, or nurse practitioner and has an active license or approval to practice medical acts, tasks, or functions issued by the Board, or any current or retired judge of the Office of Administrative Hearings, a State district court, a State superior court, the North Carolina Court of Appeals, the North Carolina Supreme Court, or of the federal judiciary who has an active license to practice law in North Carolina and who is a member in good standing of the North Carolina State Bar.

(3) Integrative medicine. – A diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

(4) License. – An authorization issued by the Board to a physician or physician assistant to practice medical acts, tasks, or functions.

(5) The practice of medicine or surgery. – The practice of medicine or surgery, for purposes of this Article, includes any of the following acts:

a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State.

b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual.

c. Offering or undertaking to prevent or diagnose, correct, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition.

d. Offering or undertaking to perform any surgical operation on any individual.

e. Using the designation 'Doctor,' 'Doctor of Medicine,' 'Doctor of Osteopathy,' 'Doctor of Osteopathic Medicine,' 'Physician,' 'Surgeon,' 'Physician and Surgeon,' 'Dr.,' 'M.D.,' 'D.O.,' or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of or reference to another branch of the healing arts for which the individual holds a valid license in this State or the use of the designation 'Doctor' or 'Physician' is otherwise specifically permitted by law.

f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone."

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

"**§ 90-2. Medical Board.**

(a) There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians ~~elected and nominated to the Governor by the North Carolina Medical Society.~~recommended by the Review Panel and appointed by the Governor as set forth in G.S. 90-3.

(2) ~~Of the~~The remaining five ~~members,~~members shall all ~~to~~ be appointed by the ~~Governor,~~Governor as follows:

a. ~~one~~One shall be a duly licensed physician who is a doctor of osteopathy or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in

that person's clinical practice or a member of The Old North State Medical ~~Society,~~Society. This Board position shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3.

b. ~~three~~Three shall be public ~~members and one~~members, and these Board positions shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3. A public member shall not be a health care provider nor the spouse of a health care provider. For the purpose of Board membership, "health care provider" means any licensed health care professional, agent or employee of a health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this section, a person enrolled in a program as preparation to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

c. One shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in ~~G.S. 90-18.2.~~G.S. 90-18.2 as recommended by the Review Panel pursuant to G.S. 90-3. ~~A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "health care provider" means any licensed health care professional and any agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.~~

(a1) Each appointing and nominating authority shall endeavor to see, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to gender, ethnic, racial, and age composition.

(b) No member shall serve more than two complete consecutive three-year terms, except that each member shall serve until a successor is chosen and qualifies.

(c) Repealed by Session Laws 2003-366, s. 1, effective October 1, 2003.

(d) Any member of the Board may be removed from office by the Governor for good cause shown. Any vacancy in the ~~physician~~physician, physician assistant, or nurse practitioner membership of the Board shall be filled for the period of the unexpired term by the Governor from a list ~~of physicians~~ submitted by the ~~North Carolina Medical Society Executive Council.~~Review Panel pursuant to G.S. 90-3 except as provided in G.S. 90-2(a)(2)a. Any vacancy in the ~~public, physician assistant, or nurse~~

~~practitioner~~public membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any private person or corporation, subject only to approval of the Governor and the Council of State as to the acquisition, rental, encumbering, leasing, and sale of real property. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.

SECTION 3. G.S. 90-2.1 is repealed.

SECTION 4. G.S. 90-3 reads as rewritten:

"**§ 90-3. ~~Medical Society nominates Board.~~Review Panel recommends certain Board members; criteria for recommendations.**

(a) ~~The Governor shall appoint as physician members of the Board physicians elected and nominated by the North Carolina Medical Society.~~There is created a Review Panel to review all applicants for the physician positions and the physician assistant or nurse practitioner position on the Board except as provided in G.S. 90-2(a)(2)a. The Review Panel shall consist of nine members, including four from the Medical Society, one from the Old North State Medical Society, one from the North Carolina Osteopathic Medical Association, one from the North Carolina Academy of Physician Assistants, one from the North Carolina Nurses Association Council of Nurse Practitioners, and one public member currently serving on the Board. All physicians, physician assistants, and nurse practitioners serving on the Review Panel shall be actively practicing in North Carolina.

The Review Panel shall contract for the independent administrative services needed to complete its functions and duties. The Board shall provide funds to pay the reasonable cost for the administrative services of the Review Panel. The Board shall convene the initial meeting of the Review Panel. The Review Panel shall elect a chair, and all subsequent meetings shall be convened by the Review Panel.

The Governor shall appoint Board members as provided in G.S. 90-2. The Review Panel shall attempt to make its recommendations to the Governor reflect the composition of the State with regard to gender, ethnic, racial, and age composition.

The Review Panel 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.

(b) To be considered qualified for a physician position or the physician assistant or nurse practitioner position on the Board, an applicant shall meet each of the following criteria:

(1) Hold an active, nonlimited license to practice medicine in North Carolina, or in the case of a physician assistant or nurse practitioner, hold an active license or approval to perform medical acts, tasks, and functions in North Carolina.

(2) Have an active clinical or teaching practice. For purposes of this subdivision, the term "active" means patient care, or instruction of

students in an accredited medical school or residency, or clinical research program, for 20 hours or more per week.

(3) Have actively practiced in this State for at least five consecutive years immediately preceding the appointment.

(4) Intend to remain in active practice in this State for the duration of the term on the Board.

(5) Submit at least three letters of recommendation, either from individuals or from professional or other societies or organizations.

(6) Have no public disciplinary history with the Board or any other licensing board in this State or another state over the past 10 years before applying for appointment to the Board.

(7) Have no history of felony convictions of any kind.

(8) Have no misdemeanor convictions related to the practice of medicine.

(9) Indicate, in a manner prescribed by the Review Panel, that the applicant: (i) understands that the primary purpose of the Board is to protect the public; (ii) is willing to take appropriate disciplinary action against his or her peers for misconduct or violations of the standards of care or practice of medicine; and (iii) is aware of the time commitment needed to be a constructive member of the Board.

(c) The review panel shall recommend at least two qualified nominees for each open position on the Board. If the Governor chooses not to appoint either of the recommended nominees, the Review Panel shall recommend at least two new qualified nominees.

(d) Notice of open physician positions or the physician assistant or nurse practitioner position on the Board shall be sent to all physicians currently licensed to practice medicine in North Carolina and all physician assistants and nurse practitioners currently licensed or approved to perform medical acts, tasks, and functions in this State.

(e) Applicants for positions on the Board shall not be required to be members of any professional association or society, except as provided in G.S. 90-2(a)(2)a."

SECTION 5. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.1. Powers and duties of the Board.**

(a) The Board shall:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this Article.

(4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.

(5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or nonlicensee. In the case of the death of a licensee, the rules may provide for the disposition of the medical

records by the estate of the licensee. This subsection shall not apply to records created or maintained by persons licensed under other Articles of this Chapter or to medical records maintained in the normal course of business by licensed health care institutions.

(6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.

(7) Develop educational programs to facilitate licensee awareness of provisions contained in this Article and public awareness of the role and function of the Board.

(8) Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care.

(9) Develop and implement methods to assess and improve physician practice.

(10) Develop and implement methods to ensure the ongoing competence of licensees.

(b) Nothing in subsection (a) of this section shall restrict or otherwise limit powers and duties conferred on the Board in other sections of this Article."

SECTION 6. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.2. Board to collect and publish certain data.**

(a) The Board shall require all physicians and physician assistants to report to the Board certain information, including, but not limited to, the following:

(1) The names of any schools of medicine or osteopathy attended and the year of graduation.

(2) Any graduate medical or osteopathic education at any institution approved by the Accreditation Council of Graduate Medical Education, the Committee for the Accreditation of Canadian Medical Schools, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(3) Any specialty board of certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(4) Specialty area of practice.

(5) Hospital affiliations.

(6) Address and telephone number of the primary practice setting.

(7) An e-mail address or facsimile number which shall not be made available to the public and shall be used for the purpose of expediting the dissemination of information about a public health emergency.

(8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.

(9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food

and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.

(10) Conviction of a felony.

(11) Conviction of certain misdemeanors, occurring within the last 10 years, in accordance with rules adopted by the Board.

(12) Any medical license, active or inactive, granted by another state or country.

(13) Certain malpractice information received pursuant to G.S. 90-14.13 or from other sources in accordance with rules adopted by the Board.

(a1) Except as provided, the Board shall make information collected under G.S. 90-5.2(a) available to the public.

(b) The Board may adopt rules to implement this section.

(c) Failure to provide information as required by this section and in accordance with Board rules or knowingly providing false information may be considered unprofessional conduct as defined in G.S. 90-14(a)(6)."

SECTION 7. G.S. 90-6(a) is recodified as G.S. 90-8.1; G.S. 90-6(b) and (c), respectively, are recodified as G.S. 90-8.2(a) and (b), respectively; G.S. 90-12.1 is recodified as G.S. 90-12.4; G.S. 90-12.2 is recodified as G.S. 90-12.5; G.S. 90-15 is recodified as G.S. 90-13.1; and G.S. 90-15.1 is recodified as G.S. 90-13.2.

SECTION 8. G.S. 90-8.1, as recodified in Section 7 of this act, reads as rewritten:

"**§ 90-8.1. Rules governing applicants for ~~license, examinations, etc.; appointment of subcommittees.~~licensure.**

~~(a)~~ The North Carolina Medical Board is empowered to ~~prescribe such~~adopt rules ~~as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.~~that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures."

SECTION 9. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-9.1. Requirements for licensure as a physician under this Article.**

(a) Except as provided in G.S. 90-9.2, to be eligible for licensure as a physician under this Article, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has passed each part of an examination described in G.S. 90-10.1;

(2) Is a graduate of:

a. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association and has successfully completed one year of training in a medical education program approved by the Board after graduation from medical school; or

b. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of

Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency program approved by the Board before completion of medical school; and

(3) Is of good moral character.

(b) No license may be granted to any applicant who graduated from a medical or osteopathic college that has been disapproved by the Board pursuant to rules adopted by the Board.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.2. Requirements for graduates of foreign medical schools.**

(a) To be eligible for licensure under this section, an applicant who is a graduate of a medical school not approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or the American Osteopathic Association shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed three years of training in a medical education program approved by the Board after graduation from medical school;

(2) Is of good moral character;

(3) Has a currently valid standard certificate of Educational Commission for Foreign Medical Graduates (ECFMG); and

(4) Is able to communicate in English.

(b) The Board may waive ECFMG certification if the applicant:

(1) Has passed the ECFMG examination and successfully completed an approved Fifth Pathway Program. The applicant is required to provide the original ECFMG Certification Status Report from the ECFMG; or

(2) Has been licensed in another state on the basis of written examination before the establishment of ECFMG in 1958.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.3. Requirements for licensure as a physician assistant.**

(a) To be eligible for licensure as a physician assistant, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by the Committee's predecessor or successor entities;

(2) Holds or previously held a certificate issued by the National Commission on Certification of Physician Assistants; and

(3) Is of good moral character.

(b) Before initiating practice of medical acts, tasks, or functions as a physician assistant, the physician assistant shall provide the Board the name, address, and telephone number of the physician who will supervise the physician assistant in the relevant medical setting.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate. The Board may set fees for physician assistants pursuant to rules adopted by the Board."

SECTION 10. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-10.1. Examinations accepted by the Board.**

The Board may administer or accept the following examinations for licensure:

(1) A State Board licensing examination.

(2) The National Board of Medical Examiners (NBME) examination or its successor.

(3) The United States Medical Licensing Examination (USMLE) of this section or its successor.

(4) The Federation Licensing Examination (FLEX) or its successor.

(5) Other examinations the Board deems equivalent to the examinations described in subdivisions (1) through (3) of this section pursuant to rules adopted by the Board."

SECTION 11. G.S. 90-11 reads as rewritten:

"**§ 90-11. ~~Qualifications of applicant for license.~~Criminal background checks.**

~~(a) Every applicant for a license to practice medicine or to perform medical acts, tasks, and functions as a physician 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 any such license is granted by the Board to the applicant.~~

~~(b)~~ The Department of Justice may provide a criminal record check to the Board for a person who has applied for a 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 12. G.S. 90-12 is repealed.

SECTION 13.(a) G.S. 90-13.1, as recodified in Section 7 of this act, reads as rewritten:

"**§ 90-13.1. License ~~fee; salaries, fees, and expenses of Board.~~ fees.**

Each applicant for a license to practice medicine and surgery in this State under either G.S. 90-9, 90-10, or 90-13 shall pay to the North Carolina Medical Board an application fee of three hundred fifty dollars ($350.00). 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 one hundred dollars ($100.00), 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.~~"

SECTION 13.(b) Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-13.3. Salaries, fees, expenses of the Board.**

(a) 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.

(b) The per diem compensation of Board members shall not exceed two hundred dollars ($200.00) per member for time spent in the performance and discharge of duties as a member. Any unexpended sum 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."

SECTION 14. G.S. 90-14 reads as rewritten:

"**§ 90-14. ~~Revocation, suspension, annulment or denial of license~~Disciplinary Authority.**

(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, an application, request or petition for reinstatement or reactivation of a license, an annual registration of a license, or an investigation or inquiry by the Board.

(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.~~patients or failing to maintain acceptable standards of one or more areas of professional physician practice. 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, 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.

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 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.

...."

SECTION 15. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before disciplinary action.~~revocation or suspension of a license.~~**

Before the Board shall ~~revoke, restrict or suspend~~take disciplinary action against any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 16. G.S. 90-14.3 reads as rewritten:

"**§ 90-14.3. Service of notices.**

Any notice required by this Chapter may be served either personally by an employee of the Board or by an officer authorized by law to serve process, or by registered or certified mail, return receipt requested, directed to the licensee or applicant at his last known address as shown by the records of the Board. If notice is served personally, it shall be deemed to have been served at the time when the officer or employee of the Board delivers the notice to the person ~~addressed.~~addressed or delivers the notice at the licensee's or applicant's last known address as shown by records of the Board with a person of suitable age and discretion then residing therein. Where notice is served by registered or certified mail, it shall be deemed to have been served on the date borne by the return receipt showing delivery of the notice to the ~~addressee, showing refusal of the addressee to accept the notice, or showing failure to locate the addressee at the last known address as shown by the records of the Board.~~licensee's or applicant's last known address as shown by the records of the Board, regardless of whether the notice was actually received or whether the notice was unclaimed or undeliverable for any reason."

SECTION 17. G.S. 90-14.4 is repealed.

SECTION 18. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of hearing committee and ~~depositions.~~depositions; appointment of hearing officers.**

(a) The Board, in its discretion, may designate in writing three or more ~~of its members~~hearing officers 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.

(d) Hearing officers are entitled to receive per diem compensation and reimbursement for expenses as authorized by the Board. The per diem compensation shall not exceed the amount allowed by G.S. 90-13.3."

SECTION 19. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

(a) ~~In~~ Except as otherwise provided in proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, in proceedings held pursuant to this Article, the ~~licensee~~ individual under investigation may call witnesses, including medical practitioners licensed in the United ~~States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony.~~States with training and experience in the same field of practice as the individual under investigation and familiar with the standard of care among members of the same health care profession in North Carolina. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article. Documentary evidence may be received in the form of a copy or excerpt or may be incorporated by reference, if the materials so incorporated are available for examination by the parties. Upon timely request, a party shall be given an opportunity to compare the copy with the original if available.

(d) When evidence is not reasonably available under the Rules of Civil Procedure and Rules of Evidence to show relevant facts, then the most reliable and substantial evidence available shall be admitted."

SECTION 20. G.S. 90-14.8 reads as rewritten:

"**§ 90-14.8. Appeal from Board's decision taking disciplinary action on a license. ~~revoking or suspending a license.~~**

A physician whose license is revoked or suspended by the Board may obtain a review of the decision of the Board in the Superior Court of Wake County ~~or in the~~

~~superior court in the county in which the hearing was held or upon agreement of the parties to the appeal in any other superior court of the State,~~ upon filing with the secretary of the Board a written notice of appeal within 20 days after the date of the service of the decision of the Board, stating all exceptions taken to the decision of the Board and indicating the court in which the appeal is to be heard.

Within 30 days after the receipt of a notice of appeal as herein provided, the Board shall prepare, certify and file with the clerk of ~~the superior court in the county to which the appeal is directed~~the Superior Court of Wake County the record of the case comprising a copy of the charges, notice of hearing, transcript of testimony, and copies of documents or other written evidence produced at the hearing, decision of the Board, and notice of appeal containing exceptions to the decision of the Board."

SECTION 21. G.S. 90-14.10 reads as rewritten:

"**§ 90-14.10. Scope of review.**

Upon the review of the Board's decision ~~revoking or suspending~~taking disciplinary action on a license, the case shall be heard by the judge without a jury, upon the record, except that in cases of alleged omissions or errors in the record, testimony thereon may be taken by the court. The court may affirm the decision of the Board or remand the case for further proceedings; or it may reverse or modify the decision if the substantial rights of the accused physician have been prejudiced because the findings or decisions of the Board are in violation of substantive or procedural law, or are not supported by competent, material, and substantial evidence admissible under this Article, or are arbitrary or capricious. At any time after the notice of appeal has been filed, the court may remand the case to the Board for the hearing of any additional evidence which is material and is not cumulative and which could not reasonably have been presented at the hearing before the Board."

SECTION 22. 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.**

(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.~~license.

(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 by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, complaint or, disciplinary 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 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~~ subsections (d) and (e1) 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.~~Board and transcripts of any deposition taken by Board counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.

(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.

(e1) When the Board receives a complaint regarding the care of a patient, the Board shall inform the complainant of the disposition of the Board's inquiry into the complaint and the Board's basis for that disposition. Upon written request of a patient, the Board may provide the patient a licensee's written response to a complaint filed by the patient with the Board regarding the patient's care. Upon written request of a complainant, who is not the patient but is authorized by State and federal law to receive protected health information about the patient, the Board may provide the complainant a licensee's written response to a complaint filed with the Board regarding the patient's care. Any information furnished to the patient or complainant pursuant to this subsection shall be inadmissible in evidence in any civil proceeding. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were included in the Board's review or were

the subject of information furnished to the patient or complainant pursuant to this subsection."

(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~~ may report the information to the appropriate law enforcement ~~agency.~~agency or district attorney of the district in which the offense was committed.

(i) The Board shall cooperate with and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the investigating ~~agency.~~agency or district attorney. Information disclosed by the Board to an investigative agency or district attorney 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 or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities 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 23. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; ~~practicing defined;~~ penalties.**

(a) No person shall perform any act constituting the practice of medicine or surgery, as defined in this Article, 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, 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.

~~(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.~~

(c) The following shall not constitute practicing medicine or surgery as defined in ~~subsection (b) of this section:~~this Article:

(1) The administration of domestic or family ~~remedies in cases of emergency.~~remedies.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and rules developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of ~~chiropody~~podiatric medicine and surgery by any legally licensed ~~chiropodist~~podiatric physician when engaged in the practice of ~~chiropody, and without the use of any drug.~~podiatry as defined in Article 12A of this Chapter.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(11a) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery so long as:

a. The physician or surgeon has an oral or written agreement with a sports team to provide general or emergency medical care to the team members, coaching staff, or families traveling with the team for a specific sporting event taking place in this State; and

b. The physician or surgeon does not provide care or consultation to any person residing in this State other than an individual described in sub-subdivision a. of this subdivision.

The exemption shall remain in force while the physician or surgeon is traveling with the team. The exemption shall not exceed 10 days per individual sporting event. However, the executive director of the Board may grant a physician or surgeon additional time for exemption of up to 20 additional days per individual sporting event.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by

use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State.

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.
b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.
c. The physician receives no compensation for the services.
d. The physician provides those services within this State for no more than 30 days per calendar year.
e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

SECTION 24. G.S. 90-18.1(a) reads as rewritten:

"(a) Any person who is licensed under the provisions of G.S. ~~90-11~~90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician may use the title "physician assistant". Any other person who uses the title in any form or holds out to be a physician assistant or to be so licensed, shall be deemed to be in violation of this Article."

SECTION 25. G.S. 90-18.1 is amended by adding the following new subsections to read:

"(g) Any person who is licensed under G.S. 90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician shall comply with each of the following:

(1) Maintain a current and active license to practice in this State.
(2) Maintain an active registration with the Board.
(3) Have a current Intent to Practice form filed with the Board.

(h) A physician assistant serving active duty in the United States military is exempt from the requirements of subdivision (g)(3) of this section.

(i) A physician assistant's license shall become inactive any time the holder fails to comply with the requirements of subsection (g) of this section. A physician assistant with an inactive license shall not practice medical acts, tasks, or functions. The Board shall retain jurisdiction over the holder of the inactive license."

SECTION 26. G.S. 90-21 is repealed.

SECTION 27. Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-37.2. Temporary permits for volunteer dentists.**

(a) The North Carolina State Board of Dental Examiners may issue to a person who is not licensed to practice dentistry in this State and who is a graduate of a Board-approved dental school, college, or institution a temporary volunteer permit authorizing such person to practice dentistry under the supervision or direction of a dentist duly licensed in this State. A temporary volunteer permit shall be issued only to those dentists who are licensed in another Board-approved state or jurisdiction, have never been subject to discipline, and have passed a patient-based clinical examination substantially similar to the clinical examination offered in this State. The issuance of a temporary volunteer permit is subject to the following conditions:

(1) A temporary volunteer permit shall be valid no more than one year from the date of issue; provided, however, that the Board may renew the permit for additional one-year periods.

(2) The holder of a temporary volunteer permit may practice only under the supervision or direction of one or more dentists duly licensed to practice in this State.

(3) The holder of a temporary volunteer permit may practice dentistry only: (i) as a volunteer in a hospital, sanatorium, temporary clinic, or like institution which is licensed or approved by the State of North Carolina and approved by the Board; (ii) as a volunteer for a nonprofit health care facility serving low-income populations and approved by the State Health Director or his designee or approved by the Board; or (iii) as a volunteer for the State of North Carolina or an agency or political subdivision thereof, or any other governmental entity within the State of North Carolina, when such service is approved by the Board.

(4) The holder of a temporary volunteer permit shall receive no fee or monetary compensation of any kind or nature for any dental service performed.

(5) The practice of dentistry by the holder of a temporary volunteer permit shall be strictly limited to the confines of and to the registered patients of the hospital, sanatorium, temporary clinic, or approved nonprofit health care facilities for which he is working or to the patients officially served by the governmental entity to which he is offering his volunteer services.

(6) The holder of a temporary volunteer permit shall be subject to discipline by the Board for those actions constituting the practice of dentistry by G.S. 90-29 occurring while practicing in this State.

(7) Any person seeking a temporary volunteer permit must file with the Board such proof as is required by the Board to determine if the applicant has a valid unrestricted dental license in another state or jurisdiction, has not been subject to discipline by any licensing board, has a proven record of clinical safety and is otherwise qualified to practice dentistry in this State.

(8) There shall be no fee associated with the issuance of a temporary volunteer permit for the practice of dentistry.

(b) The Board is authorized to make rules consistent with this section to regulate the practice of dentistry for those issued a temporary volunteer permit.

SECTION 28. Sections 2 and 4 of this act become effective January 1, 2008. The remainder of this act becomes effective October 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 4

HOUSE BILL 818*

Committee Substitute Favorable 5/4/07
Committee Substitute #2 Favorable 5/14/07
Committee Substitute #3 Favorable 6/12/07

Short Title: Amend Practice of Medicine Laws.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

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

"**§ 90-1A. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Medical Board.

(2) Hearing officer. – Any current or past member of the Board who is a physician, physician assistant, or nurse practitioner and has an active license or approval to practice medical acts, tasks, or functions issued by the Board, or any current or retired judge of the Office of Administrative Hearings, a State district court, a State superior court, the North Carolina Court of Appeals, the North Carolina Supreme Court, or of the federal judiciary who has an active license to practice law in North Carolina and who is a member in good standing of the North Carolina State Bar.

(3) Integrative medicine. – A diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

(4) License. – An authorization issued by the Board to a physician or physician assistant to practice medical acts, tasks, or functions.

(5) The practice of medicine or surgery. – The practice of medicine or surgery, for purposes of this Article, includes any of the following acts:

a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State.

b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual.

c. Offering or undertaking to prevent or diagnose, correct, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition.

d. Offering or undertaking to perform any surgical operation on any individual.

e. Using the designation 'Doctor,' 'Doctor of Medicine,' 'Doctor of Osteopathy,' 'Doctor of Osteopathic Medicine,' 'Physician,' 'Surgeon,' 'Physician and Surgeon,' 'Dr.,' 'M.D.,' 'D.O.,' or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of or reference to another branch of the healing arts for which the individual holds a valid license in this State or the use of the designation 'Doctor' or 'Physician' is otherwise specifically permitted by law.

f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone."

SECTION 2. G.S. 90-2.1 is repealed.

SECTION 3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.1. Powers and duties of the Board.**

(a) The Board shall:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this Article.

(4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.

(5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or nonlicensee. In the case of the death of a licensee, the rules may provide for the disposition of the medical records by the estate of the licensee. This subsection shall not apply to

records created or maintained by persons licensed under other Articles of this Chapter or to medical records maintained in the normal course of business by licensed health care institutions.

(6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.

(7) Develop educational programs to facilitate licensee awareness of provisions contained in this Article and public awareness of the role and function of the Board.

(8) Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care.

(9) Develop and implement methods to assess and improve physician practice.

(10) Develop and implement methods to ensure the ongoing competence of licensees.

(b) Nothing in subsection (a) of this section shall restrict or otherwise limit powers and duties conferred on the Board in other sections of this Article."

SECTION 4. G.S. 90-6(a) is recodified as G.S. 90-8.1; G.S. 90-6(b) and (c), respectively, are recodified as G.S. 90-8.2(a) and (b), respectively; G.S. 90-12.1 is recodified as G.S. 90-12.4; G.S. 90-12.2 is recodified as G.S. 90-12.5; G.S. 90-15 is recodified as G.S. 90-13.1; and G.S. 90-15.1 is recodified as G.S. 90-13.2.

SECTION 5. G.S. 90-8.1, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-8.1. Rules governing applicants for ~~license, examinations, etc.; appointment of subcommittees.~~licensure.**

~~(a)~~ The North Carolina Medical Board is empowered to ~~prescribe such~~adopt rules ~~as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.~~that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures."

SECTION 6. G.S. 90-8.2, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-8.2. Appointment of subcommittees.**

(a) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). ~~The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00).~~ Rules developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and shall become effective when adopted by both the North Carolina Medical Board and the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these rules.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina Board of Pharmacy to develop rules to govern the performance of medical acts by clinical pharmacist practitioners, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). ~~The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00).~~ Rules recommended by the subcommittee shall be adopted in accordance with Chapter 150B of the General Statutes by both the North Carolina Medical Board and the North Carolina Board of Pharmacy and shall not become effective until adopted by both Boards. The North Carolina Medical Board shall have responsibility for ensuring compliance with these rules."

SECTION 7. G.S. 90-9 and G.S. 90-10 are repealed.

SECTION 8. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-9.1. Requirements for licensure as a physician under this Article.**

(a) Except as provided in G.S. 90-9.2, to be eligible for licensure as a physician under this Article, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has passed each part of an examination described in G.S. 90-10.1;

(2) Is a graduate of:

a. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association and has successfully completed one year of training in a medical education program approved by the Board after graduation from medical school; or

b. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency program approved by the Board before completion of medical school; and

(3) Is of good moral character.

(b) No license may be granted to any applicant who graduated from a medical or osteopathic college that has been disapproved by the Board pursuant to rules adopted by the Board.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.2. Requirements for graduates of foreign medical schools.**

(a) To be eligible for licensure under this section, an applicant who is a graduate of a medical school not approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or the American Osteopathic Association shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed three years of training in a medical education program approved by the Board after graduation from medical school;

(2) Is of good moral character;

(3) Has a currently valid standard certificate of Educational Commission for Foreign Medical Graduates (ECFMG); and

(4) Is able to communicate in English.

(b) The Board may waive ECFMG certification if the applicant:

(1) Has passed the ECFMG examination and successfully completed an approved Fifth Pathway Program. The applicant is required to provide the original ECFMG Certification Status Report from the ECFMG; or

(2) Has been licensed in another state on the basis of written examination before the establishment of ECFMG in 1958.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-9.3. Requirements for licensure as a physician assistant.**

(a) To be eligible for licensure as a physician assistant, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by the Committee's predecessor or successor entities;

(2) Holds or previously held a certificate issued by the National Commission on Certification of Physician Assistants; and

(3) Is of good moral character.

(b) Before initiating practice of medical acts, tasks, or functions as a physician assistant, the physician assistant shall provide the Board the name, address, and telephone number of the physician who will supervise the physician assistant in the relevant medical setting.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate. The Board may set fees for physician assistants pursuant to rules adopted by the Board.

"**§ 90-10.1. Examinations accepted by the Board.**

The Board may administer or accept the following examinations for licensure:

(1) A State Board licensing examination.

(2) The National Board of Medical Examiners (NBME) examination or its successor.

(3) The United States Medical Licensing Examination (USMLE) of this section or its successor.

(4) The Federation Licensing Examination (FLEX) or its successor.

(5) Other examinations the Board deems equivalent to the examinations described in subdivisions (1) through (3) of this section pursuant to rules adopted by the Board."

SECTION 9. G.S. 90-11 reads as rewritten:

"**§ 90-11. ~~Qualifications of applicant for license.~~Criminal background checks.**

~~(a) Every applicant for a license to practice medicine or to perform medical acts, tasks, and functions as a physician 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 any such license is granted by the Board to the applicant.~~

~~(b)~~ The Department of Justice may provide a criminal record check to the Board for a person who has applied for a 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 10. G.S. 90-12 and G.S. 90-13 are repealed.

SECTION 11. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-12A. Limited license to practice in a medical education and training program.**

(a) As provided in rules adopted by the Board, the Board may issue a limited license known as a 'resident's training license' to a physician not otherwise licensed by the Board who is participating in a graduate medical education training program.

(b) A resident's training license shall become inactive at the time its holder ceases to be a resident in a training program or obtains any other license to practice medicine issued by the Board. The Board shall retain jurisdiction over the holder of the inactive license.

"**§ 90-12.1A. Limited volunteer license.**

(a) The Board may issue a 'military limited volunteer license' to an applicant who:

(1) Has a license to practice medicine and surgery in another state;

(2) Produces a letter from the state of licensure indicating the applicant is in good standing; and

(3) Is authorized to treat personnel enlisted in a branch of the United States armed services or veterans.

(b) The Board may issue a 'retired limited volunteer license' to an applicant who is a retired physician and has allowed his or her license to practice medicine and surgery in this State or another state to become inactive.

(c) A physician holding a limited license under this section shall comply with the continuing medical education requirements pursuant to rules adopted by the Board.

(d) The Board shall issue a limited license under this section within 30 days after an applicant provides the Board with information satisfying the requirements of this section.

(e) The holder of a limited license under this section may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients. The holder of the limited license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

(f) The holder of a limited license issued pursuant to this section who practices medicine or surgery at places other than clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

(g) The Board may, by rule, require an applicant for a limited license under this section to comply with other requirements or submit additional information the Board deems appropriate.

"**§ 90-12.2A. Special purpose license.**

(a) The Board may issue a special purpose license to practice medicine to an applicant who:

(1) Holds a full and unrestricted license to practice in at least one other jurisdiction; and

(2) Does not have any current or pending disciplinary or other action against him or her by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the special purpose license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the special purpose license.

(c) The Board may adopt rules and set fees as appropriate to implement the provisions of this section.

"**§ 90-12.3. Medical school faculty license.**

(a) The Board may issue a medical school faculty license to practice medicine and surgery to a physician who:

(1) Holds a full-time appointment as either a lecturer, assistant professor, associate professor, or full professor at one of the following medical schools:

a. Duke University School of Medicine;
b. The University of North Carolina at Chapel Hill School of Medicine;
c. Wake Forest University School of Medicine; or
d. East Carolina University School of Medicine; and

(2) Is not subject to disciplinary order or other action by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the medical school faculty license issued under this section shall not practice medicine or surgery outside the confines of the medical school or an affiliate of the medical school. The holder of the medical school faculty license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the medical school faculty license.

(c) The Board may adopt rules and set fees related to issuing medical school faculty licenses. The Board may, by rule, set a time limit for the term of a medical school faculty license."

SECTION 12. G.S. 90-13.1, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-13.1. License ~~fee; salaries, fees, and expenses of Board.~~fees.**

(a) Each applicant for a license to practice medicine and surgery in this State under either G.S. ~~90-9, 90-10, or 90-13~~90-9.1 or G.S. 90-9.2 shall pay to the North Carolina Medical Board an application fee of three hundred fifty dollars ($350.00).

(b) ~~Whenever~~ Each applicant for a limited license ~~is granted as provided in~~to practice in a medical education and training program under G.S. ~~90-12, the applicant~~90-12A shall pay to the Board a fee ~~not to exceed~~of one hundred ~~fifty~~ dollars ($100.00). ~~($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 one hundred dollars ($100.00), and~~

(c) ~~where~~ An applicant for a limited volunteer license ~~to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients is granted, the applicant~~under G.S. 90-12.1A shall not pay a fee.

(d) A fee of twenty-five dollars ($25.00) shall be paid for the issuance of a duplicate license.

(e) 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.~~"

SECTION 13. G.S. 90-13.2, as recodified in Section 4 of this act, reads as rewritten:

"**§ 90-13.2. Registration every year with Board.**

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday.

(b) A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay ~~a~~ an annual registration fee of one hundred seventy-five dollars ($175.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ($125.00) and those who have a limited volunteer license shall pay an annual registration fee of twenty-five dollars ($25.00). However, licensees who have a limited license to practice for the purpose of education and training under G.S. 90-12A shall not be required to pay more than one annual registration fee for each year of training.

(c) A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.

(d) For purposes of annual registration, the Board shall use a simplified registration form which allows registrants to confirm information on file with the Board.

(e) A physician who fails to register as required by this section shall pay an additional fee of fifty dollars ($50.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is automatically inactive. The Board shall retain jurisdiction over the holder of the inactive license.

(f) Except as provided in G.S. ~~90-12(d),~~90-12.1A, a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee.

(g) Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. ~~90-13.~~90-13.1."

SECTION 14. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-13.3. Salaries, fees, expenses of the Board.**

(a) 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.

(b) The per diem compensation of Board members shall not exceed two hundred dollars ($200.00) per member for time spent in the performance and discharge of duties as a member. Any unexpended sum 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."

SECTION 15. G.S. 90-14 reads as rewritten:

"**§ 90-14. ~~Revocation, suspension, annulment or denial of license~~Disciplinary Authority.**

(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, an application, request or petition for reinstatement or reactivation of a license, an annual registration of a license, or an investigation or inquiry by the Board.

(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 © 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.~~patients or failing to maintain acceptable standards of one or more areas of professional physician practice. 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, 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.

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 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.

...."

SECTION 16. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before disciplinary action.~~revocation or suspension of a license.~~**

Before the Board shall ~~revoke, restrict or suspend~~take disciplinary action against any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 17. G.S. 90-14.4 is repealed.

SECTION 18. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of hearing committee and ~~depositions.~~depositions; appointment of hearing officers.**

(a) The Board, in its discretion, may designate in writing three or more ~~of its members~~hearing officers 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.

(d) Hearing officers are entitled to receive per diem compensation and reimbursement for expenses as authorized by the Board. The per diem compensation shall not exceed the amount allowed by G.S. 90-13.3."

SECTION 19. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

(a) ~~In~~ Except as otherwise provided in proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, in proceedings held pursuant to this Article, the ~~licensee~~ individual under investigation may call witnesses, including medical practitioners licensed in the United ~~States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony.~~States with training and experience in the same field of practice as the individual under investigation and familiar with the standard of care among members of the same health care profession in North Carolina. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article. Documentary evidence may be received in the form of a copy or excerpt or may be incorporated by reference, if the materials so incorporated are available for examination by the parties. Upon timely request, a party shall be given an opportunity to compare the copy with the original if available.

(d) When evidence is not reasonably available under the Rules of Civil Procedure and Rules of Evidence to show relevant facts, then the most reliable and substantial evidence available shall be admitted."

SECTION 20. G.S. 90-14.8 reads as rewritten:

"**§ 90-14.8. Appeal from Board's decision taking disciplinary action on a license. ~~revoking or suspending a license.~~**

A physician whose license is revoked or suspended by the Board may obtain a review of the decision of the Board in the Superior Court of Wake County ~~or in the superior court in the county in which the hearing was held or upon agreement of the parties to the appeal in any other superior court of the State,~~ upon filing with the secretary of the Board a written notice of appeal within 20 days after the date of the

service of the decision of the Board, stating all exceptions taken to the decision of the Board and indicating the court in which the appeal is to be heard.

Within 30 days after the receipt of a notice of appeal as herein provided, the Board shall prepare, certify and file with the clerk of ~~the superior court in the county to which the appeal is directed~~the Superior Court of Wake County the record of the case comprising a copy of the charges, notice of hearing, transcript of testimony, and copies of documents or other written evidence produced at the hearing, decision of the Board, and notice of appeal containing exceptions to the decision of the Board."

SECTION 21. G.S. 90-14.10 reads as rewritten:

"**§ 90-14.10. Scope of review.**

Upon the review of the Board's decision ~~revoking or suspending~~taking disciplinary action on a license, the case shall be heard by the judge without a jury, upon the record, except that in cases of alleged omissions or errors in the record, testimony thereon may be taken by the court. The court may affirm the decision of the Board or remand the case for further proceedings; or it may reverse or modify the decision if the substantial rights of the accused physician have been prejudiced because the findings or decisions of the Board are in violation of substantive or procedural law, or are not supported by competent, material, and substantial evidence admissible under this Article, or are arbitrary or capricious. At any time after the notice of appeal has been filed, the court may remand the case to the Board for the hearing of any additional evidence which is material and is not cumulative and which could not reasonably have been presented at the hearing before the Board."

SECTION 22. 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.**

(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.~~license.

(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 by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, complaint or, disciplinary 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 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~~ subsections (d) and (f) 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.~~Board and transcripts of any deposition taken by Board counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.

(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) When the Board receives a complaint regarding the care of a patient, the Board shall inform the complainant of the disposition of the Board's inquiry into the complaint and the Board's basis for that disposition. Upon written request of a patient, the Board may provide the patient a licensee's written response to a complaint filed by the patient with the Board regarding the patient's care. Upon written request of a complainant, who is not the patient but is authorized by State and federal law to receive protected health information about the patient, the Board may provide the complainant a licensee's written response to a complaint filed with the Board regarding the patient's care. Any information furnished to the patient or complainant pursuant to this subsection shall be inadmissible in evidence in any civil proceeding. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were included in the Board's review or were the subject of information furnished to the patient or complainant pursuant to this subsection."

~~(f)~~(g) 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)~~(h) 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)~~(i) If investigative information in the possession of the Board, its employees, or agents indicates that a crime may have been committed, the Board ~~shall~~ may report the information to the appropriate law enforcement ~~agency.~~agency or district attorney of the district in which the offense was committed.

~~(i)~~(j) The Board shall cooperate with and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the investigating ~~agency.~~agency or district attorney. Information disclosed by the Board to an investigative agency or district attorney remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation.

~~(j)~~(k) 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)~~(l) The Board, its members and staff, may release confidential or nonpublic information to any health care licensure board in this State or another state or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities 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 23. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; ~~practicing defined;~~ penalties.**

(a) No person shall perform any act constituting the practice of medicine or surgery, as defined in this Article, 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, 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.

~~(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.~~

(c) The following shall not constitute practicing medicine or surgery as defined in ~~subsection (b) of this section:~~this Article:

(1) The administration of domestic or family ~~remedies in cases of emergency.~~remedies.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and rules developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of ~~chiropody~~podiatric medicine and surgery by any legally licensed ~~chiropodist~~podiatric physician when engaged in the practice of ~~chiropody, and without the use of any drug.~~podiatry as defined in Article 12A of this Chapter.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(11a) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery so long as:

a. The physician or surgeon has an oral or written agreement with a sports team to provide general or emergency medical care to the team members, coaching staff, or families traveling with the team for a specific sporting event taking place in this State; and

b. The physician or surgeon does not provide care or consultation to any person residing in this State other than an individual described in sub-subdivision a. of this subdivision.

The exemption shall remain in force while the physician or surgeon is traveling with the team. The exemption shall not exceed 10 days per individual sporting event. However, the executive director of the Board may grant a physician or surgeon additional time for exemption of up to 20 additional days per individual sporting event.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a

human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State.

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.

b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.
c. The physician receives no compensation for the services.
d. The physician provides those services within this State for no more than 30 days per calendar year.
e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

SECTION 24. G.S. 90-18.1(a) reads as rewritten:

"(a) Any person who is licensed under the provisions of G.S. ~~90-11~~90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician may use the title "physician assistant". Any other person who uses the title in any form or holds out to be a physician assistant or to be so licensed, shall be deemed to be in violation of this Article."

SECTION 25. G.S. 90-18.1 is amended by adding the following new subsections to read:

"(g) Any person who is licensed under G.S. 90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician shall comply with each of the following:

(1) Maintain a current and active license to practice in this State.
(2) Maintain an active registration with the Board.
(3) Have a current Intent to Practice form filed with the Board.

(h) A physician assistant serving active duty in the United States military is exempt from the requirements of subdivision (g)(3) of this section.

(i) A physician assistant's license shall become inactive any time the holder fails to comply with the requirements of subsection (g) of this section. A physician assistant with an inactive license shall not practice medical acts, tasks, or functions. The Board shall retain jurisdiction over the holder of the inactive license."

SECTION 26. G.S. 90-21 is repealed.

SECTION 27. This act becomes effective October 1, 2007.

HOUSE BILL 818:
Amend Practice of Medicine Laws.-AB

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	July 24, 2007
Introduced by:	Rep. Allen	**Summary by:**	Ben Popkin Committee Counsel
Version:	PCS to Fourth Edition H818-CSRD		

SUMMARY: ***HB 818 makes changes to Article 1 (Practice of Medicine) in Chapter 90 (Medicine and Allied Occupations) of the General Statutes. Changes include restructuring and reorganizing existing law, enacting new sections of law, authorizing temporary permits for volunteer dentists, and codifying provisions currently provided for by rule. As introduced, this bill was identical to SB 864.***

[As introduced, this bill was identical to S864, as introduced by Sen. Purcell, which is currently in Senate Finance.]

CURRENT LAW: The North Carolina Medical Board is a 12 member board that regulates the practice of medicine and surgery in the State. The duties of the Board include the evaluation of applicants and issuance of the following licenses if the Board finds that the applicant meets specified qualifications: license to practice medicine and surgery, license to practice as physician assistant, resident's training license, limited volunteer license, medical school faculty limited license, and physician assistant limited volunteer license. The Board's authority also includes the revocation, suspension, annulment, and denial of a license.

BILL ANALYSIS: House Bill 818 makes the following changes to Article 1 of Chapter 90:
Section 1 inserts a definition section into Article 1 of Chapter 90. Most of these defined terms are not present in Article 1. The section defines the following terms: Board, hearing officer, integrative medicine, license, and the practice of medicine or surgery.[1]

Section 2 revises the Board membership appointment process to require that certain positions on the Board shall be selected from recommendations by a newly established Review Panel.

Section 4 creates a Review Panel to review applications and recommend applicants to be appointed by the Governor to serve as the physician members of the Board and as the physician assistant or nurse practitioner member of the Board. This section establishes criteria which applicants must satisfy to pursue a position on the Board, sets provisions relating to notice for open Board positions, and requires that appointment of certain Board members by the Governor must be from among those recommended by the Review Panel.

Section 5 sets out the powers and duties of the Board. New duties include regulating the retention and disposition of medical records, and methods to ensure the ongoing competence of licensees.

Section 6 enacts a new section to require all physicians and physician assistants to report certain information to the Board, which the Board must then make available to the public. Information includes:

[1] The term "practice of medicine and surgery" includes representation that the individual is authorized to practice medicine in the State, and the use of the designation, "Doctor," Doctor of Medicine," "Doctor of Osteopathic Medicine," 'Physician," "Surgeon," etc. in the conduct of an occupation pertaining to the prevention, diagnosis, or treatment of human disease or condition.

training, certification and specialty information, contact information, disciplinary actions, criminal convictions, and licensure and malpractice information.

Section 7 recodifies a series of statutes.

Section 8 amends G.S. 90-8.1 concerning the power of the Medical Board to adopt rules.

Section 9 repeals G.S. 90-9 and G.S. 90-10 concerning examination for licensure.

Section 10 enacts new provisions addressing requirements for licensure as a physician, as a physician assistant, and as a physician graduate of a foreign medical school, including the new requirement that foreign medical graduates must be able to communicate in English.

Section 11 specifies the examinations for licensure that the Board will accept.

Section 12 amends G.S. 90-11 to remove language now contained elsewhere in the law, renames the section and retains the criminal background check provision.

Section 13 repeals G.S.90-12 (Limited license; limited volunteer license), and G.S. 90-13 (When license without examination allowed.)

Sections 14a and 14b reenact existing provisions in G.S. 90-15 governing salaries, fees and expenses of the Board as new G.S. 90-13.1 and G.S. 90-13.3.

Section 15 renames the statute relating to the Board's authority as "disciplinary" authority. This section adds the following as grounds for Board disciplinary action: (1) willful concealment from the Board of material information in connection with an application, request or petition for reinstatement or reactivation of a license, an annual registration of a license, or an investigation or inquiry by the Board; and (2) failure to maintain acceptable standards of one or more areas of professional physician practice.

Sections 16, 17, 18, 19, 20, 21 and 22 make changes regarding hearings for revocation or suspension of license, evidence admissible in hearings, service of notice, and filing appeals.
Current law: A hearing for revocation or suspension of a physician's license has historically taken place in Wake County. The statute also provides that a physician may request that the hearing be conducted in the county of the physician's residence. The Board, in its discretion, may designate three or more of its members to conduct the hearing. The Board shall admit and hear evidence in the same manner and form as in civil legal actions. A physician may appeal the Board's decision to Wake County Superior Court, to the superior court in the county in which the hearing was held, or upon agreement of the parties to any other superior court. A Board member may receive per diem compensation of not more than $200.

House Bill 818 repeals the statute governing the location of a hearing. A hearing would be held at a location set by the Board and conducted by three or more hearing officers designated by the Board. A hearing officer is any current or past member of the Board who is a currently licensed physician, PA or nurse practitioner; any current or retired judge of the Office of Administrative Hearings; a State district court, a State superior court, the N.C. Court of Appeals, the N.C. Supreme Court, or the federal judiciary who has an active law license and who is a member in good standing of the N.C. State Bar. The hearing officers may receive compensation and reimbursement as authorized in Article 1 The per diem compensation may not exceed more than $200. An appeal of the Board's decision may be heard only in Wake County Superior Court.

Section 23 makes the following changes to the statute governing self-reporting requirements; confidentiality of Board investigative information; cooperation with law enforcement; patient protection; Board to keep public records:

- Repeals requirement that names of new licensees must be published in three newspapers; publication on web site will suffice.
- Provides that depositions taken by the Board counsel in preparation for or anticipation of a hearing but not admitted into evidence at a hearing are confidential.
- Requires the Board to notify a complainant of the disposition of the Board's inquiry into a complaint regarding patient care and the Board's basis for the disposition of the inquiry into the complaint. If a patient who files a complaint or a complainant who is not a patient but who is authorized to receive information about the patient, makes a written request, the Board may provide the patient or complainant a licensee's written response to the complaint.
- Provides that if the Board, its employees, or agents are in possession of investigative information that indicates a crime may have been committed, the Board may report the information to the appropriate law enforcement agency or district attorney of the district in which the offense was committed. (Current law requires the Board to report the information to the appropriate law enforcement agency.)
- Provides that the Board shall cooperate and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing relevant information. (Current law requires the Board to cooperate and assist a law enforcement agency conducting a criminal investigation only.)
- Authorizes the Board to release confidential or nonpublic information to authorized DHHS personnel with enforcement or investigative responsibilities.

Section 23 adds the following act to the existing list of acts that do not constitute the practice of medicine or surgery: The practice of medicine or surgery by a physician who comes into the State to provide care to a sports team under an oral or written agreement with the sports team. The exemption shall not exceed 10 days per individual sporting event. The executive director of the Board may grant the physician up to 20 additional days per individual sporting event.

Section 25 amends the section governing limitations on physician assistants (PAs) by restating the existing requirements and the rules of the Board for a PA to have a current and active license to practice in the State, a current registration with the Board, and a current intent to practice filed with the Board (unless on active military duty). The Board retains jurisdiction over a PA with an inactive license.

Section 27 enacts a new section to authorize the Board of Dental Examiners to issue temporary permits for volunteer dentists in certain circumstances.

EFFECTIVE DATE: Sections 2 and 4 of this act become effective January 1, 2008 and the remainder of this act becomes effective October 1, 2007.

Martha Walston, counsel to House Finance, substantially contributed to this summary.

H0818e4-SMRD-CSRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 818*

Committee Substitute Favorable 5/4/07
Committee Substitute #2 Favorable 5/14/07
Committee Substitute #3 Favorable 6/12/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H818-CSSQ-61 [v.3]

7/24/2007 11:41:42 PM

Short Title: Amend Practice of Medicine Laws.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF MEDICINE AND TO AMEND THE LAWS PERTAINING TO THE PRACTICE OF DENTISTRY.

The General Assembly of North Carolina enacts:

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

"**§ 90-1A. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Medical Board.

(2) Hearing officer. – Any current or past member of the Board who is a physician, physician assistant, or nurse practitioner and has an active license or approval to practice medical acts, tasks, or functions issued by the Board, or any current or retired judge of the Office of Administrative Hearings, a State district court, a State superior court, the North Carolina Court of Appeals, the North Carolina Supreme Court, or of the federal judiciary who has an active license to practice law in North Carolina and who is a member in good standing of the North Carolina State Bar.

(3) Integrative medicine. – A diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

(4) License. – An authorization issued by the Board to a physician or physician assistant to practice medical acts, tasks, or functions.

(5) The practice of medicine or surgery. – The practice of medicine or surgery, for purposes of this Article, includes any of the following acts:

a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State.

b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual.

c. Offering or undertaking to prevent or diagnose, correct, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition.

d. Offering or undertaking to perform any surgical operation on any individual.

e. Using the designation 'Doctor,' 'Doctor of Medicine,' 'Doctor of Osteopathy,' 'Doctor of Osteopathic Medicine,' 'Physician,' 'Surgeon,' 'Physician and Surgeon,' 'Dr.,' 'M.D.,' 'D.O.,' or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of or reference to another branch of the healing arts for which the individual holds a valid license in this State or the use of the designation 'Doctor' or 'Physician' is otherwise specifically permitted by law.

f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone."

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

"**§ 90-2. Medical Board.**

(a) There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 12 members.

(1) Seven of the members shall be duly licensed physicians ~~elected and nominated to the Governor by the North Carolina Medical Society.~~recommended by the Review Panel and appointed by the Governor as set forth in G.S. 90-3.

(2) ~~Of the~~The remaining five ~~members,~~members shall all to be appointed by the ~~Governor,~~Governor as follows:

a. ~~one~~One shall be a duly licensed physician who is a doctor of osteopathy or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in

that person's clinical practice or a member of The Old North State Medical ~~Society,~~Society. This Board position shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3.

b. ~~three~~Three shall be public ~~members and one~~members, and these Board positions shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3. A public member shall not be a health care provider nor the spouse of a health care provider. For the purpose of Board membership, "health care provider" means any licensed health care professional, agent or employee of a health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this section, a person enrolled in a program as preparation to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

c. One shall be a physician assistant as defined in G.S. 90-18.1 or a nurse practitioner as defined in ~~G.S. 90-18.2.~~G.S. 90-18.2 recommended by the Review Panel pursuant to G.S. 90-3.~~A public member shall not be a health care provider nor the spouse of a health care provider. For purposes of board membership, "health care provider" means any licensed health care professional and any agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this section, a person enrolled in a program to prepare him to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.~~

(a1) Each appointing and nominating authority shall endeavor to see, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to gender, ethnic, racial, and age composition.

(b) No member shall serve more than two complete consecutive three-year terms, except that each member shall serve until a successor is chosen and qualifies.

(c) Repealed by Session Laws 2003-366, s. 1, effective October 1, 2003.

(d) Any member of the Board may be removed from office by the Governor for good cause shown. Any vacancy in the ~~physician~~physician, physician assistant, or nurse practitioner membership of the Board shall be filled for the period of the unexpired term by the Governor from a list ~~of physicians~~ submitted by the ~~North Carolina Medical Society Executive Council.~~Review Panel pursuant to G.S. 90-3 except as provided in G.S. 90-2(a)(2)a. Any vacancy in the ~~public, physician assistant, or nurse~~

~~practitioner~~public membership of the Board shall be filled by the Governor for the unexpired term.

(e) The North Carolina Medical Board shall have the power to acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as any private person or corporation, subject only to approval of the Governor and the Council of State as to the acquisition, rental, encumbering, leasing, and sale of real property. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.

SECTION 3. G.S. 90-2.1 is repealed.

SECTION 4. G.S. 90-3 reads as rewritten:

"§ 90-3. ~~Medical Society nominates Board.~~Review Panel recommends certain Board members; criteria for recommendations.

(a) ~~The Governor shall appoint as physician members of the Board physicians elected and nominated by the North Carolina Medical Society.~~There is created a Review Panel to review all applicants for the physician positions and the physician assistant or nurse practitioner position on the Board except as provided in G.S. 90-2(a)(2)a. The review panel shall consist of nine members, including four from the Medical Society, one from the Old North State Medical Society, one from the North Carolina Osteopathic Medical Association, one from the North Carolina Academy of Physician Assistants, one from the North Carolina Nurses Association Council of Nurse Practitioners, and one public member currently serving on the Board. All physicians, physician assistants, and nurse practitioners serving on the Review Panel shall be actively practicing in North Carolina.

The Review Panel shall contract for the independent administrative services needed to complete its functions and duties. The Board shall provide funds to pay the reasonable cost for the administrative services of the Review Panel. The Board shall convene the initial meeting of the Review Panel. The Review Panel shall elect a chair, and all subsequent meetings shall be convened by the Review Panel.

The Governor shall appoint Board members as provided in G.S. 90-2. The Review Panel shall attempt to make its recommendations to the Governor reflect the composition of the State with regard to gender, ethnic, racial, and age composition.

The Review Panel 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.

(b) To be considered qualified for a physician position or the physician assistant or nurse practitioner position on the Board, an applicant shall meet each of the following criteria:

(1) Hold an active, non-limited license to practice medicine in North Carolina, or in the case of a physician assistant or nurse practitioner, hold an active license or approval to perform medical acts, tasks, and functions in North Carolina.

(2) Have an active clinical or teaching practice. For purposes of this subdivision, the term "active" means patient care, or instruction of

students in an accredited medical school or residency, or clinical research program, for 20 hours or more per week.

(3) Have actively practiced in this State for at least five consecutive years immediately preceding the appointment.

(4) Intend to remain in active practice in this State for the duration of the term on the Board.

(5) Submit at least three letters of recommendation, either from individuals or from professional or other societies or organizations.

(6) Have no public disciplinary history with the Board or any other licensing board in this State or another state over the past 10 years before applying for appointment to the Board.

(7) Have no history of felony convictions of any kind.

(8) Have no misdemeanor convictions related to the practice of medicine.

(9) Indicate, in a manner prescribed by the Review Panel, that the applicant: (i) understands that the primary purpose of the Board is to protect the public; (ii) is willing to take appropriate disciplinary action against his or her peers for misconduct or violations of the standards of care or practice of medicine; and (iii) is aware of the time commitment needed to be a constructive member of the Board.

(c) The review panel shall recommend at least two qualified nominees for each open position on the Board.

(d) Notice of open physician positions or the physician assistant or nurse practitioner position on the Board shall be sent to all physicians currently licensed to practice medicine in North Carolina and all physician assistants and nurse practitioners currently licensed or approved to perform medical acts, tasks, and functions in this State.

(e) Applicants for positions on the Board shall not be required to be members of any professional association or society, except as provided in G.S. 90-2(a)(2)a."

SECTION 5. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.1. Powers and duties of the Board.**

(a) The Board shall:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this Article.

(4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.

(5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or nonlicensee. In the case of the death of a licensee, the rules may provide for the disposition of the medical records by the estate of the licensee. This subsection shall not apply to records created or maintained by persons licensed under other Articles

of this Chapter or to medical records maintained in the normal course of business by licensed health care institutions.

(6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.

(7) Develop educational programs to facilitate licensee awareness of provisions contained in this Article and public awareness of the role and function of the Board.

(8) Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care.

(9) Develop and implement methods to assess and improve physician practice.

(10) Develop and implement methods to ensure the ongoing competence of licensees.

(b) Nothing in subsection (a) of this section shall restrict or otherwise limit powers and duties conferred on the Board in other sections of this Article."

SECTION 6. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-5.2 Board to collect and publish certain data.

(a) The Board shall require all physicians and physician assistants to report to the Board certain information, including but not limited to the following:

(1) The names of any schools of medicine or osteopathy attended and the year of graduation.

(2) Any graduate medical or osteopathic education at any institution approved by the Accreditation Council of Graduate Medical Education, the Committee for the Accreditation of Canadian Medical Schools, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(3) Any specialty board of certification as approved by the American Board of Medical Specialties, Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(4) Specialty area of practice.

(5) Hospital affiliations.

(6) Address and telephone number of the primary practice setting.

(7) An email address or facsimile number which shall not be made available to the public and shall be used for the purpose of expediting the dissemination of information about a public health emergency.

(8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.

(9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.

(10) Conviction of a felony.
(11) Conviction of certain misdemeanors, occurring within the last ten years, in accordance with rules adopted by the Board.
(12) Any medical license, active or inactive, granted by another state or country.
(13) Certain malpractice information received pursuant to G.S. 90-14.13 or from other sources in accordance with rules adopted by the Board.

(a1) Except as provided, the Board shall make information collected under G.S. 90-5.2(a) available to the public.

(b) The Board may adopt rules to implement this section.

(c) Failure to provide information as required by this section and in accordance with Board rules or knowingly providing false information may be considered unprofessional conduct as defined in G.S. 90-14(a)(6). "

SECTION 7. G.S. 90-6(a) is recodified as G.S. 90-8.1; G.S. 90-6(b) and (c), respectively, are recodified as G.S. 90-8.2(a) and (b), respectively; G.S. 90-12.1 is recodified as G.S. 90-12.4; G.S. 90-12.2 is recodified as G.S. 90-12.5; G.S. 90-15 is recodified as G.S. 90-13.1; and G.S. 90-15.1 is recodified as G.S. 90-13.2.

SECTION 8. G.S. 90-8.1, as recodified in Section 7 of this act, reads as rewritten:

"**§ 90-8.1. Rules governing applicants for ~~license, examinations, etc.; appointment of subcommittees.~~licensure.**

~~(a)~~ The North Carolina Medical Board is empowered to ~~prescribe such~~adopt rules ~~as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.~~that prescribe additional qualifications for an applicant, including education and examination requirements and application procedures."

SECTION 9. G.S. 90-9 and G.S. 90-10 are repealed.

SECTION 10. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-9.1. Requirements for licensure as a physician under this Article.**

(a) Except as provided in G.S. 90-9.2, to be eligible for licensure as a physician under this Article, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has passed each part of an examination described in G.S. 90-10.1;
(2) Is a graduate of:
a. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association and has successfully completed one year of training in a medical education program approved by the Board after graduation from medical school; or
b. A medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved

by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency program approved by the Board before completion of medical school; and

(3) Is of good moral character.

(b) No license may be granted to any applicant who graduated from a medical or osteopathic college that has been disapproved by the Board pursuant to rules adopted by the Board.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"§ 90-9.2. Requirements for graduates of foreign medical schools.

(a) To be eligible for licensure under this section, an applicant who is a graduate of a medical school not approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or the American Osteopathic Association shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed three years of training in a medical education program approved by the Board after graduation from medical school;

(2) Is of good moral character;

(3) Has a currently valid standard certificate of Educational Commission for Foreign Medical Graduates (ECFMG); and

(4) Is able to communicate in English.

(b) The Board may waive ECFMG certification if the applicant:

(1) Has passed the ECFMG examination and successfully completed an approved Fifth Pathway Program. The applicant is required to provide the original ECFMG Certification Status Report from the ECFMG; or

(2) Has been licensed in another state on the basis of written examination before the establishment of ECFMG in 1958.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate.

"§ 90-9.3. Requirements for licensure as a physician assistant.

(a) To be eligible for licensure as a physician assistant, an applicant shall submit proof satisfactory to the Board that the applicant:

(1) Has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by the Committee's predecessor or successor entities;

(2) Holds or previously held a certificate issued by the National Commission on Certification of Physician Assistants; and

(3) Is of good moral character.

(b) Before initiating practice of medical acts, tasks, or functions as a physician assistant, the physician assistant shall provide the Board the name, address, and telephone number of the physician who will supervise the physician assistant in the relevant medical setting.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate. The Board may set fees for physician assistants pursuant to rules adopted by the Board.

SECTION 11. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-10.1. Examinations accepted by the Board.**

The Board may administer or accept the following examinations for licensure:

(1) A State Board licensing examination.

(2) The National Board of Medical Examiners (NBME) examination or its successor.

(3) The United States Medical Licensing Examination (USMLE) of this section or its successor.

(4) The Federation Licensing Examination (FLEX) or its successor.

(5) Other examinations the Board deems equivalent to the examinations described in subdivisions (1) through (3) of this section pursuant to rules adopted by the Board."

SECTION 12. G.S. 90-11 reads as rewritten:

"**§ 90-11. ~~Qualifications of applicant for license.~~Criminal background checks.**

~~(a) Every applicant for a license to practice medicine or to perform medical acts, tasks, and functions as a physician 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 any such license is granted by the Board to the applicant.~~

~~(b)~~ The Department of Justice may provide a criminal record check to the Board for a person who has applied for a 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 13. G.S. 90-12 and G.S. 90-13 are repealed.

SECTION 14a. G.S. 90-13.1, as recodified in Section 7 of this act, reads as rewritten:

"§ 90-13.1. License ~~fee; salaries, fees, and expenses of Board.~~ fees.

Each applicant for a license to practice medicine and surgery in this State under either G.S. 90-9, 90-10, or 90-13 shall pay to the North Carolina Medical Board an application fee of three hundred fifty dollars ($350.00). 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 one hundred dollars ($100.00), 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.~~"

SECTION 14b. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-13.3. Salaries, fees, expenses of the Board.

(a) 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.

(b) The per diem compensation of Board members shall not exceed two hundred dollars ($200.00) per member for time spent in the performance and discharge of duties as a member. Any unexpended sum 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."

SECTION 15. G.S. 90-14 reads as rewritten:

"§ 90-14. ~~Revocation, suspension, annulment or denial of license~~Disciplinary Authority.

(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, an application, request or petition for reinstatement or reactivation of a license, an annual registration of a license, or an investigation or inquiry by the Board.

(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.~~patients or failing to maintain acceptable standards of one or more areas of professional physician practice. 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, 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.

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 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.

...."

SECTION 16. G.S. 90-14.2 reads as rewritten:

"**§ 90-14.2. Hearing before disciplinary action.~~revocation or suspension of a license.~~**

Before the Board shall ~~revoke, restrict or suspend~~take disciplinary action against any license granted by it, the licensee shall be given a written notice indicating the general nature of the charges, accusation, or complaint made against him, which notice may be prepared by a committee or one or more members of the Board designated by the Board, and stating that such licensee will be given an opportunity to be heard concerning such charges or complaint at a time and place stated in such notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of such notice upon such licensee, at which such licensee may appear personally and through counsel, may cross examine witnesses and present evidence in his own behalf. A physician who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the physician has his residence. Such licensee or physician may, if he desires, file written answers to the charges or complaints preferred against him within 30 days after the service of such notice, which answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 17. G.S. 90-14.3 reads as rewritten:

"**§ 90-14.3. Service of notices.**

Any notice required by this Chapter may be served either personally by an employee of the Board or by an officer authorized by law to serve process, or by registered or certified mail, return receipt requested, directed to the licensee or applicant at his last known address as shown by the records of the Board. If notice is served personally, it shall be deemed to have been served at the time when the officer or employee of the Board delivers the notice to the person ~~addressed.~~addressed or delivers the notice at the licensee's or applicant's last known address as shown by records of the Board with a person of suitable age and discretion then residing therein. Where notice is served by registered or certified mail, it shall be deemed to have been served on the date borne by the return receipt showing delivery of the notice to the ~~addressee, showing refusal of the addressee to accept the notice, or showing failure to locate the addressee at the last known address as shown by the records of the Board.~~licensee's or applicant's last known address as shown by the records of the Board, regardless of whether the notice was actually received or whether the notice was unclaimed or undeliverable for any reason.

SECTION 18. G.S. 90-14.4 is repealed.

SECTION 19. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of hearing committee and ~~depositions.~~depositions; appointment of hearing officers.**

(a) The Board, in its discretion, may designate in writing three or more ~~of its members~~hearing officers 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.

(d) Hearing officers are entitled to receive per diem compensation and reimbursement for expenses as authorized by the Board. The per diem compensation shall not exceed the amount allowed by G.S. 90-13.3."

SECTION 20. G.S. 90-14.6 reads as rewritten:

"§ 90-14.6. Evidence admissible.

(a) ~~In~~ Except as otherwise provided in proceedings held pursuant to this Article the Board shall admit and hear evidence in the same manner and form as prescribed by law for civil actions. A complete record of such evidence shall be made, together with the other proceedings incident to such hearing.

(b) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, in proceedings held pursuant to this Article, the ~~licensee~~ individual under investigation may call witnesses, including medical practitioners licensed in the United ~~States, with expertise in the same field of practice as the licensee under investigation, and the Board shall consider this testimony.~~States with training and experience in the same field of practice as the individual under investigation and familiar with the standard of care among members of the same health care profession in North Carolina. Witnesses shall not be restricted to experts certified by the American Board of Medical Specialties.

(c) Subject to the North Carolina Rules of Civil Procedure and Rules of Evidence, statements contained in medical or scientific literature shall be competent evidence in proceedings held pursuant to this Article. Documentary evidence may be received in the form of a copy or excerpt or may be incorporated by reference, if the materials so incorporated are available for examination by the parties. Upon timely request, a party shall be given an opportunity to compare the copy with the original if available.

(d) When evidence is not reasonably available under the Rules of Civil Procedure and Rules of Evidence to show relevant facts, then the most reliable and substantial evidence available shall be admitted."

SECTION 21. G.S. 90-14.8 reads as rewritten:

"§ 90-14.8. Appeal from Board's decision taking disciplinary action on a license. ~~revoking or suspending a license.~~

A physician whose license is revoked or suspended by the Board may obtain a review of the decision of the Board in the Superior Court of Wake County ~~or in the~~

~~superior court in the county in which the hearing was held or upon agreement of the parties to the appeal in any other superior court of the State,~~ upon filing with the secretary of the Board a written notice of appeal within 20 days after the date of the service of the decision of the Board, stating all exceptions taken to the decision of the Board and indicating the court in which the appeal is to be heard.

Within 30 days after the receipt of a notice of appeal as herein provided, the Board shall prepare, certify and file with the clerk of ~~the superior court in the county to which the appeal is directed~~the Superior Court of Wake County the record of the case comprising a copy of the charges, notice of hearing, transcript of testimony, and copies of documents or other written evidence produced at the hearing, decision of the Board, and notice of appeal containing exceptions to the decision of the Board."

SECTION 22. G.S. 90-14.10 reads as rewritten:

"**§ 90-14.10. Scope of review.**

Upon the review of the Board's decision ~~revoking or suspending~~taking disciplinary action on a license, the case shall be heard by the judge without a jury, upon the record, except that in cases of alleged omissions or errors in the record, testimony thereon may be taken by the court. The court may affirm the decision of the Board or remand the case for further proceedings; or it may reverse or modify the decision if the substantial rights of the accused physician have been prejudiced because the findings or decisions of the Board are in violation of substantive or procedural law, or are not supported by competent, material, and substantial evidence admissible under this Article, or are arbitrary or capricious. At any time after the notice of appeal has been filed, the court may remand the case to the Board for the hearing of any additional evidence which is material and is not cumulative and which could not reasonably have been presented at the hearing before the Board."

SECTION 23. 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.**

(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.~~license.

(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 by the Board, or its members or employees as a result of investigations, inquiries or interviews conducted in connection with a licensing, complaint or, disciplinary 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 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~~ subsections (d) and (e1) 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.~~Board and transcripts of any deposition taken by Board counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.

(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.

(e1) When the Board receives a complaint regarding the care of a patient, the Board shall inform the complainant of the disposition of the Board's inquiry into the complaint and the Board's basis for that disposition. Upon written request of a patient, the Board may provide the patient a licensee's written response to a complaint filed by the patient with the Board regarding the patient's care. Upon written request of a complainant, who is not the patient but is authorized by State and federal law to receive protected health information about the patient, the Board may provide the complainant a licensee's written response to a complaint filed with the Board regarding the patient's care. Any information furnished to the patient or complainant pursuant to this subsection shall be inadmissible in evidence in any civil proceeding. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were included in the Board's review or were

the subject of information furnished to the patient or complainant pursuant to this subsection."

(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~~ may report the information to the appropriate law enforcement ~~agency.~~agency or district attorney of the district in which the offense was committed.

(i) The Board shall cooperate with and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the investigating ~~agency.~~agency or district attorney. Information disclosed by the Board to an investigative agency or district attorney 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 or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities 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 23. G.S. 90-18 reads as rewritten:

"**§ 90-18. Practicing without license; ~~practicing defined;~~ penalties.**

(a) No person shall perform any act constituting the practice of medicine or surgery, as defined in this Article, 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, 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.

~~(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.~~

(c) The following shall not constitute practicing medicine or surgery as defined in ~~subsection (b) of this section:~~this Article:

(1) The administration of domestic or family ~~remedies in cases of emergency.~~remedies.

(2) The practice of dentistry by any legally licensed dentist engaged in the practice of dentistry and dental surgery.

(3) The practice of pharmacy by any legally licensed pharmacist engaged in the practice of pharmacy.

(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and rules developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as: (i) the implementation of predetermined drug therapy which includes diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; (i), (ii), and (iii) shall be pursuant to an agreement that is physician, pharmacist, patient, and disease specific.

(4) The practice of medicine and surgery by any surgeon or physician of the United States army, navy, or public health service in the discharge of his official duties.

(5) The treatment of the sick or suffering by mental or spiritual means without the use of any drugs or other material means.

(6) The practice of optometry by any legally licensed optometrist engaged in the practice of optometry.

(7) The practice of midwifery as defined in G.S. 90-178.2.

(8) The practice of ~~chiropody~~podiatric medicine and surgery by any legally licensed ~~chiropodist~~podiatric physician when engaged in the practice of ~~chiropody, and without the use of any drug.~~podiatry as defined in Article 12A of this Chapter.

(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.

(10) The practice of chiropractic by any legally licensed chiropractor when engaged in the practice of chiropractic as defined by law, and without the use of any drug or surgery.

(11) The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

(11a) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery so long as:

a. The physician or surgeon has an oral or written agreement with a sports team to provide general or emergency medical care to the team members, coaching staff, or families traveling with the team for a specific sporting event taking place in this State; and

b. The physician or surgeon does not provide care or consultation to any person residing in this State other than an individual described in sub-subdivision a. of this subdivision.

The exemption shall remain in force while the physician or surgeon is traveling with the team. The exemption shall not exceed 10 days per individual sporting event. However, the executive director of the Board may grant a physician or surgeon additional time for exemption of up to 20 additional days per individual sporting event.

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. "Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by

use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.

(13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

(14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.

(15) The practice of dietetics/nutrition by a licensed dietitian/nutritionist under the provisions of Article 25 of this Chapter.

(16) The practice of acupuncture by a licensed acupuncturist in accordance with the provisions of Article 30 of this Chapter.

(17) The use of an automated external defibrillator as provided in G.S. 90-21.15.

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of the Internet or a toll-free telephone number while the physician's patient is temporarily in this State.

(19) The practice of medicine or surgery by any physician who comes into this State to practice medicine or surgery at a camp that specializes in providing therapeutic recreation for individuals with chronic illnesses, as long as all the following conditions are satisfied:

a. The physician provides documentation to the medical director of the camp that the physician is licensed and in good standing to practice medicine in another state.
b. The physician provides services only at the camp or in connection with camp events or camp activities that occur off the grounds of the camp.
c. The physician receives no compensation for the services.
d. The physician provides those services within this State for no more than 30 days per calendar year.
e. The camp has a medical director who holds an unrestricted license to practice medicine and surgery issued under this Article."

SECTION 24. G.S. 90-18.1(a) reads as rewritten:

"(a) Any person who is licensed under the provisions of G.S. ~~90-11~~90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician may use the title "physician assistant". Any other person who uses the title in any form or holds out to be a physician assistant or to be so licensed, shall be deemed to be in violation of this Article."

SECTION 25. G.S. 90-18.1 is amended by adding the following new subsections to read:

"(g) Any person who is licensed under G.S. 90-9.3 to perform medical acts, tasks, and functions as an assistant to a physician shall comply with each of the following:

(1) Maintain a current and active license to practice in this State.
(2) Maintain an active registration with the Board.
(3) Have a current Intent to Practice form filed with the Board.

(h) A physician assistant serving active duty in the United States military is exempt from the requirements of subdivision (g)(3) of this section.

(i) A physician assistant's license shall become inactive any time the holder fails to comply with the requirements of subsection (g) of this section. A physician assistant with an inactive license shall not practice medical acts, tasks, or functions. The Board shall retain jurisdiction over the holder of the inactive license."

SECTION 26. G.S. 90-21 is repealed.

SECTION 27. Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-37.2 Temporary permits for volunteer dentists**

(a) The North Carolina State Board of Dental Examiners may issue to a person who is not licensed to practice dentistry in this State and who is a graduate of a Board-approved dental school, college, or institution, a temporary volunteer permit authorizing such person to practice dentistry under the supervision or direction of a dentist duly licensed in this State. A temporary volunteer permit shall be issued only to those dentists who are licensed in another Board-approved state or jurisdiction, have never been subject to discipline, and have passed a patient-based clinical examination substantially similar to the clinical examination offered in this State. The issuance of a temporary volunteer permit is subject to the following conditions:

(1) A temporary volunteer permit shall be valid no more than one year from the date of issue; provided, however, that the Board may renew the permit for additional one-year periods.

(2) The holder of a temporary volunteer permit may practice only under the supervision or direction of one or more dentists duly licensed to practice in this State.

(3) The holder of a temporary volunteer permit may practice dentistry only: (i) as a volunteer in a hospital, sanatorium, temporary clinic, or like institution which is licensed or approved by the State of North Carolina and approved by the Board; (ii) as a volunteer for a non-profit health care facility serving low-income populations and approved by the State Health Director or his designee or approved by the Board; or (iii) as a volunteer for the State of North Carolina or an agency or political subdivision thereof, or any other governmental entity within the State of North Carolina, when such service is approved by the Board.

(4) The holder of a temporary volunteer permit shall receive no fee or monetary compensation of any kind or nature for any dental service performed.

(5) The practice of dentistry by the holder of a temporary volunteer permit shall be strictly limited to the confines of and to the registered patients of the hospital, sanatorium, temporary clinic, or approved non-profit health care facilities for which he is working or to the patients officially served by the governmental entity to which he is offering his volunteer services.

(6) The holder of a temporary volunteer permit shall be subject to discipline by the Board for those actions constituting the practice of dentistry by G.S. §90-29 occurring while practicing in this State.

(7) Any person seeking a temporary volunteer permit must file with the Board such proof as is required by the Board to determine if the applicant has a valid unrestricted dental license in another state or jurisdiction, has not been subject to discipline by any licensing board, has a proven record of clinical safety and is otherwise qualified to practice dentistry in this State.

(8) There shall be no fee associated with the issuance of a temporary volunteer permit for the practice of dentistry.

(b) The Board is authorized to make rules consistent with this section to regulate the practice of dentistry for those issued a temporary volunteer permit.

SECTION 27. Sections 2 and 4 of this act become effective January 1, 2008. The remainder of this act becomes effective October 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 915

Short Title:	Assisted Living Facility Amendments.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:	Health Care.	

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL, ORGANIZATIONAL, AND NONSUBSTANTIVE CHANGES ONLY TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS FOR PURPOSES OF CLARIFICATION OF THE CURRENT LAW.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.

"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D reads as rewritten:

"Article 1.

~~Licensing of Facilities.~~

Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Effective July 1, 2007, Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Part to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) "Abuse." – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) "Administrator." – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(3) "Adult care home." – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

(4) "Amenities." – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(5) "Assisted living residence." – 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging, providing information on their location and number of units operated. This type of housing is not considered assisted living. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. 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.

(6) "Compensatory agent." – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) "Department." – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) "Exploitation." – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) "Family care home." – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Facility Services and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) "Neglect." – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) "Personal care services." – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) "Registration." – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this subsection.

(14) "Resident." – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) "Secretary." – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.**

(a) Adult Care Homes. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Individuals requiring continuous licensed nursing care;

(3) Individuals whose physician certifies that placement is no longer appropriate;

(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and

(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing;

(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this State;

(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases

such as tuberculosis and excluding infections such as the common cold;

(5) Psychotropic medications without appropriate diagnosis and treatment plans;

(6) Nasogastric tubes;

(7) Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this State;

(8) Individuals requiring continuous licensed nursing care;

(9) Individuals whose physician certifies that placement is no longer appropriate;

(10) Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment instrument;

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:

(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.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3., the Department of Health and Human Services shall inspect and license all adult care homes. 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 thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

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

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of 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 not renew a license 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 require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"§ 131D-2.5. License fees.

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"§ 131D-2.6. Legal action by Department.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"§ 131D-2.7. Provisional license; license revocation.

(a) Provisional License. – Except as otherwise provided in this section, 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:

(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;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) 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 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.

(b) License Revocation. – The Department may revoke a license whenever:

(1) 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; and

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

(2) 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; and

b. 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.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor, and upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(a) State Inspection and Monitoring. – 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. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations 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. 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) State Review of County Compliance. – 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.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic 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.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – 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.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Facility Services' complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of his records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of admitting the resident and annually thereafter. In conducting the assessment, the facility shall use an assessment instrument approved by the Secretary upon the advice of the Director of the Division of Aging. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

The facility shall use the assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral

to the resident's physician or other appropriate licensed health care professional or community resource.

(b) The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall determine:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§ 131D-2.17. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living

residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 915
PROPOSED COMMITTEE SUBSTITUTE S915-CSSQ-60 [v.2]

7/24/2007 8:56:20 PM

Short Title: Assisted Living Facility Amendments. (Public)

Sponsors:

Referred to:

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.

"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D reads as rewritten:

"Article 1.

~~Licensing of Facilities.~~

Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Part to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) "Abuse." – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) "Administrator." – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(3) "Adult care home." – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

(4) "Amenities." – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(5) "Assisted living residence." – 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging, providing information on their location and number of units operated. This type of housing is not considered assisted living. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. 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.

(6) "Compensatory agent." – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) "Department." – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) "Exploitation." – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) "Family care home." – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Health Service Regulation and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) "Neglect." – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) "Personal care services." – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) "Registration." – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this subsection.

(14) "Resident." – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) "Secretary." – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.**

(a) Adult Care Homes. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Individuals requiring continuous licensed nursing care;

(3) Individuals whose physician certifies that placement is no longer appropriate;

(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and

(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing;

(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this State;

(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases

such as tuberculosis and excluding infections such as the common cold;

(5) Psychotropic medications without appropriate diagnosis and treatment plans;

(6) Nasogastric tubes;

(7) Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this State;

(8) Individuals requiring continuous licensed nursing care;

(9) Individuals whose physician certifies that placement is no longer appropriate;

(10) Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment instrument;

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:

(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.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3., the Department of Health and Human Services shall inspect and license all adult care homes. 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 thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

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

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of 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 not renew a license 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 require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation.**

(a) Provisional License. – Except as otherwise provided in this section, 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:

(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;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) 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 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.

(b) License Revocation. – The Department may revoke a license whenever:

(1) 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; and

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

(2) 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; and

b. 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 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.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor, and upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(a) State Inspection and Monitoring. – 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 Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up 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 Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation 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.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic 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 Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – 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.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of his records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of admitting the resident and annually thereafter. In conducting the assessment, the facility shall use an assessment instrument approved by the Secretary upon the advice of the Director of the Division of Aging. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

The facility shall use the assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical

functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

(b) The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall determine:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§ 131D-2.17. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3. This act becomes effective October 1, 2007. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2007, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

SENATE BILL 915:
Assisted Living Facility Amendments

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	July 25, 2007
Introduced by:	Sen. Nesbitt	**Summary by:**	Shawn Parker Legislative Analyst Susan Barham Research Assistant
Version:	PCS to First Edition S915-CSSQ-60		

SUMMARY: ***Senate Bill 915 makes technical and organizational changes to the laws regarding licensure and inspection of facilities for aged and disabled individuals.***

The Proposed Committee Substitute corrects a typographical error, changes references to the 'Division of Facility Services' to the 'Division of Health Service Regulation' per S.L. 2007-182, and changes the effective date providing for the repeal and rewriting of an act effecting licensure.

The following chart tracts the proposed changes:

Comparison			
Provision title	**SB 915**	**Existing NC law**	**Difference**
Definitions	proposed G. 131D-2.1	GS 131D-2	Renumbers defined terms
Persons not to be cared for in adult care homes & multiunit assisted housing with services; hospice care	proposed GS 131D-2.2	GS 131D-2(a1), GS 131D-2(a2), GS 131D-2(a3), & GS 131D-2(c1)	Reorganizes; Section (d) in proposed GS 131D-2.2 - Obtaining services rewritten from original language in GS 131D-2(c1)
Exemptions from licensure	proposed GS 131D-2.3	GS 131D-2(c)	
Licensure of adult care homes for aged & disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.	proposed GS 131D-2.4	GS 131D-2(b)(1), GS 131D-2(b)(6), GS 131D-2(b1),	
License fees	proposed GS 131D-2.5	GS 131D-2(b)(1)	Corrects fee schedule (SL 2005-275)
Legal action by department	proposed GS 131D-2.6	GS 131D-2(i)	
Provisional license; license revocation	proposed GS 131D-2.7	GS 131D-2(b)(1)	
Penalties	proposed GS 131D-2.8	GS 131D-2(b)(2), GS 131D-2(b)(3)	
Inspections, monitoring, and review by State agency and county departments of social services	proposed GS 131D-2.11	GS 131D-2(b)(1a)	

Training requirements; county departments of social services	proposed GS 131D-2.12	GS 131D-2(b)(1a)(d)	Proposed GS 131D-2.12(b) new language that references joint training requirements by the Department in GS 143B-139.5B
Departmental duties	proposed GS 131D-2.13(a), GS 131D - 2.13(b), GS 131D-2.13(c), GS 131D-2.13(d), GS 131D-2.13(e)	GS 131D-2(b)(1a)(e), GS 131D-2(b)(1a)(f), GS 131D-2(j), GS 131D-41, GS 131D-42	
Confidentiality	proposed GS 131D-2.14	GS 131D-2(b)(4)	
Resident assessments	proposed GS 131D-2.15	GS 131D-2(e)	
Suspension of admissions	proposed GS 131D-2.16	GS 131D-2(h)	
Rules	proposed GS 131D-2.17	GS 131D-2(c2)	
Impact on other laws; severability	proposed GS 131D-2.18	GS 131D-2(c3), GS 131D-2(f)	
Application of other laws	proposed GS 131D-2.19	N/A	

This chart was prepared by Susan Barham, Research Division, North Carolina General Assembly.

EFFECTIVE DATE: This act becomes effective October 1, 2007. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2007, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

S0915e1-SMSQ-CSSQ-60

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 915

PROPOSED COMMITTEE SUBSTITUTE S915-PCS55550-SQ-60

Short Title: Assisted Living Facility Amendments. (Public)

Sponsors:

Referred to:

March 20, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.

"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D reads as rewritten:

"Article 1.

~~Licensing of Facilities.~~

Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Parts to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) "Abuse." – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) "Administrator." – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(3) "Adult care home." – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

(4) "Amenities." – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(5) "Assisted living residence." – 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging and Adult Services, providing information on their location and number of units operated. This type of housing is not considered assisted living. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. 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.

(6) "Compensatory agent." – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) "Department." – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) "Exploitation." – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) "Family care home." – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high, and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Health Service Regulation and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and

i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) "Neglect." – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) "Personal care services." – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) "Registration." – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this section.

(14) "Resident." – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) "Secretary." – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.**

(a) Adult Care Homes. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Individuals requiring continuous licensed nursing care;

(3) Individuals whose physician certifies that placement is no longer appropriate;

(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and

(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;

(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing;

(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this State;

(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold;
(5) Psychotropic medications without appropriate diagnosis and treatment plans;
(6) Nasogastric tubes;
(7) Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this State;
(8) Individuals requiring continuous licensed nursing care;
(9) Individuals whose physician certifies that placement is no longer appropriate;
(10) Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment instrument;
(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and
(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:
(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.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. 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 thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

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

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or Type B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or

denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of 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 not renew a license 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 require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation.**

(a) Provisional License. – Except as otherwise provided in this section, 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:

(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;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) 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 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.

(b) License Revocation. – The Department may revoke a license whenever:

(1) 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; and

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

(2) 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; and

b. 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 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.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor, and, upon conviction, shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(a) State Inspection and Monitoring. – 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 Health Service Regulations shall inspect all adult care homes and adult care units in nursing homes on an annual basis. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up 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 Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation 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.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;
(2) Thirty-two hours of basic training within six months of employment;
(3) Twenty-four hours of postbasic 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 Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – 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.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of his records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of admitting the resident and annually thereafter. In conducting the assessment, the facility shall use an assessment instrument approved by the Secretary upon the advice of the Director of the Division of Aging and

Adult Services. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

The facility shall use the assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

(b) The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall determine:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§ 131D-2.17. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3. This act becomes effective October 1, 2007. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2007, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 1577

Committee Substitute Favorable 6/20/07

Short Title: Amend Hearing Aid Dealers/Fitters Laws/Fees. (Public)

Sponsors:

Referred to:

April 18, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS RELATING TO HEARING AID DEALERS AND FITTERS AND TO AUTHORIZE THE NORTH CAROLINA STATE HEARING AID DEALERS AND FITTERS BOARD TO ADD FEES.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Chapter 93D of the General Statutes and G.S. 93D-1 read as rewritten:

"**Chapter 93D.**

"**North Carolina State Hearing Aid ~~Dealers and Fitters~~Licensing Board.**

"**§ 93D-1. Definitions.**

For the purposes of this Chapter:

(1) "Board" shall mean the North Carolina State Hearing Aid ~~Dealers and Fitters~~Licensing Board.

(2) "Fitting and selling hearing aids" shall mean the evaluation or measurement of the powers or range of human hearing by means of an audiometer or by other means and the consequent selection or adaptation or sale or rental of hearing aids intended to compensate for hearing loss including the making of an impression of the ear.

(3) "Hearing aid" shall mean any instrument or device designed for or represented as aiding, improving or compensating for defective human hearing and any parts, attachments or accessories of such an instrument or device."

SECTION 2. G.S. 93D-2 reads as rewritten:

"**§ 93D-2. Fitting and selling without license unlawful.**

It shall be unlawful for any person to fit or sell hearing aids unless ~~he~~ the person has first obtained a license from the North Carolina State Hearing Aid ~~Dealers and Fitters~~Licensing Board or is an apprentice working under the supervision of a ~~board~~ Board licensee."

SECTION 3. Chapter 93D of the General Statutes is amended by adding a new section to read:

"**§ 93D-2.1. Mail order hearing aid sales.**

A person may offer hearing aids for sale, lease, or rental to persons in this State by mail order which includes catalog, direct mail, television, radio, the Internet, or any other mass media source if all the following criteria are met:

(1) The seller is licensed as a hearing aid dispenser under this Chapter.

(2) Consultation is given to the consumer either in person or by telephonic communication by a live person who is licensed as a hearing aid dispenser or is registered as an apprentice by the North Carolina State Hearing Aid Licensing Board with respect to the fitting, selection, or adaptation of the hearing aid instrument.

(3) Consultation is given to the consumer either in person or by telephonic communication by a live person who is licensed as a hearing aid dispenser or is registered as an apprentice by the North Carolina State Hearing Aid Licensing Board with respect to the taking of ear impressions for the ear mold by the seller.

(4) The seller must comply with all medical evaluation requirements pursuant to 21 CFR § 801.421.

(5) The seller must comply with all federal regulations and State rules regarding the hearing aid device."

SECTION 4. G.S. 93D-3 reads as rewritten:

"**§ 93D-3. North Carolina State Hearing Aid ~~Dealers and Fitters~~Licensing Board; composition, organization, duties and compensation.**

(a) There is hereby created a board whose duty it shall be to carry out the purposes and enforce the provisions of this Chapter, and which shall be known as the "North Carolina State Hearing Aid ~~Dealers and Fitters~~Licensing Board." The Board shall be composed of seven members. Four members who have been actively engaged in the fitting and selling of hearing aids for three years shall be appointed by the Governor. These initial appointments are for the following terms: one for one year, one for two years, one for three years and one for four years. All appointments made on or after July 1, 1981, shall be for terms of three years.

One member shall be appointed by the Governor who shall be a physician practicing in North Carolina, preferably specializing in the field of otolaryngology. All appointments shall be for terms of three years.

One member shall be appointed by the Governor from a list of two audiologists residing in North Carolina, which list shall be compiled by the North Carolina Speech and Hearing Association. This initial appointment shall be for a term of three years. All appointments made on or after July 1, 1981, shall be for a term of three years.

One member shall be appointed by the Governor to represent the interest of the public at large. This member shall have no ties to the hearing aid business nor shall he be an audiologist. The Governor shall appoint the public member not later than July 1, 1981, to serve a term of three years.

All Board members serving on June 30, 1981, shall be eligible to complete their respective terms. No member appointed to a term on or after July 1, 1981, shall serve more than two complete consecutive terms.

Vacancies on the Board shall be filled by appointment of the Governor. Appointees shall serve the unexpired term of their predecessor in office and must be appointed from the same category as their predecessor in office. The members of the Board, before entering their duties, shall respectively take all oaths taken and prescribed for other State officers, in the manner provided by law, which oaths shall be filed in the office of the Secretary of State, and the Board shall have a common seal.

(b) The Board shall choose, at the first regular meeting and annually thereafter, one of its members to serve as president and one as secretary and treasurer. A majority of the Board shall constitute a quorum. The Board shall meet at least once a year, the time and place of the annual meeting and any special meetings to be designated by the president. The secretary and treasurer of the Board shall keep a full record of its proceedings, including a current list of all licensees, which shall at all reasonable times be open to public inspection. The Board is authorized to employ an executive secretary and to provide such assistance as may be required to enable said Board to properly perform its duties.

(c) The Board shall:

(1) Authorize all disbursements necessary to carry out the provisions of this ~~Chapter;~~Chapter.

(2) Supervise and administer qualifying examinations to test and determine the knowledge and proficiency of applicants for ~~licenses;~~licensure and applicants for apprenticeship.

(3) Issue licenses to qualified persons who apply to the ~~Board;~~Board.

(4) Obtain audiometric equipment and facilities necessary to carry out the examination of applicants for ~~licenses;~~licenses.

(5) Suspend or revoke licenses pursuant to this ~~Chapter;~~Chapter.

(6) Make and publish rules, including a code of ethics, that are necessary and proper to regulate the fitting and selling of hearing aids and to carry out the provisions of this ~~Chapter;~~Chapter.

(7) Exercise jurisdiction over the hearing of complaints, charges of malpractice including corrupt or unprofessional conduct, and allegations of violations of the Board's rules that are made against any fitter and seller of hearing aids in North ~~Carolina;~~Carolina.

(8) Require the periodic inspection and calibration of audiometric testing equipment of persons who are fitting and selling hearing ~~aids;~~aids.

(9) In connection with any matter within the jurisdiction of the Board, summon and subpoena and examine witnesses under oath and to compel their attendance and the production of books, papers, or other documents or writings deemed by the Board to be necessary or material to the inquiry. Each summons or subpoena shall be issued under the hand of the secretary and treasurer or the president of the Board and shall have the force and effect of a summons or subpoena

issued by a court of record. Any witness who shall refuse or neglect to appear in obedience thereto or to testify or produce books, papers, or other documents or writings required shall be liable to contempt charges. The Board shall pay to any witness subpoenaed before it the fees and per diem as paid witnesses in civil actions in the superior court of the county where such hearing is ~~held;~~held.

(10) Inform the Attorney General of any information or knowledge it acquires regarding any "price-fixing" activity whatsoever in connection with the sales and service of hearing ~~aids;~~aids.

(11) Establish and enforce rules to guarantee that a full refund will be made within 90 days by the seller of a hearing aid to the purchaser when presented with a written medical opinion of an otolaryngologist that the purchaser's hearing cannot be improved by the use of a hearing ~~aid;~~aid.

(12) Fund, establish, conduct, approve and sponsor instructional programs for registered apprentices and for persons who hold a license as well as for persons interested in obtaining adequate instruction or programs of study to qualify them for registration to the extent that the Board deems such instructional programs to be beneficial or ~~necessary;~~necessary.

(13) Register persons ~~serving~~ applying as apprentices as set forth in ~~G.S. 93D-9;~~G.S. 93D-9.

(14) Have the power to set and collect fees in accordance with Chapter 150B of the General Statutes for the items listed in this subdivision and for other items for which this Chapter gives the Board the authority to set a fee:

a. For a continuing education make-up class provided by the Board, a fee not to exceed fifty dollars ($50.00) per person for each day of instruction. The Board may not offer a make-up class that is longer than two ~~days;~~days.

b. For a license examination preparation course provided by the Board, a fee not to exceed fifty dollars ($50.00) per person for each day of instruction. The Board may not offer an examination preparation course that is longer than three ~~days;~~days.

c. For approval of a continuing education program provider, a fee not to exceed forty dollars ~~($40.00);~~($40.00).

d. For verifying and recording attendance at a continuing education program not provided by the Board, a fee not to exceed fifteen dollars ($15.00) per licensee per ~~program;~~program.

e. For providing a voluntary two-day apprentice training workshop, a fee not to exceed one hundred dollars ($100.00) per person, and for providing a three-day voluntary apprentice

training workshop, a fee not to exceed one hundred fifty dollars ($150.00) per ~~person;~~person.

f. For administering an examination, a fee not to exceed seventy-five dollars ~~($75.00);and~~($75.00).

g. For administering a prequalifying examination to applicants for apprenticeship, a fee not to exceed twenty-five dollars ($25.00).

(15) Adopt annually a balanced budget prior to the beginning of its fiscal year, against which expenditures shall be reviewed throughout the fiscal year to ensure that expenditures during the year do not exceed receipts for that year plus amounts held by the Board in reserve. Except for monies from charges for photocopying and similar charges, the Board's receipts shall consist of and be limited to funds derived from fees expressly authorized by law.

(d) Out of the funds coming into the possession of said Board, each member thereof may receive as reimbursement for each day he is actually engaged in the assigned duties of his office, the sum of eight cents (8¢) per mile for travel plus the actual costs of meals and public lodging while away from home, which costs of meals and lodging may not exceed twenty dollars ($20.00) per day. Such expenses shall be paid from the fees and assessments received by the Board under the provisions of this Chapter. No part of these expenses or any other expenses of the Board, in any manner whatsoever, shall be paid out of the State treasury. All moneys received in excess of expense allowance and mileage, as above provided, shall be held by the secretary-treasurer as a special fund for meeting other expenses of the Board and carrying out the provisions of this Chapter.

The secretary-treasurer shall give a bond to the Board to be approved by the Board, in the sum of five thousand dollars ($5,000) conditioned upon the faithful performance of the duties of his office.

The Board shall make an annual report of its proceedings to the Governor on the first Monday in June of each year, which report shall contain an account of all moneys received and disbursed by the Board and a complete listing of names and addresses of all licensees and apprentices. Copies of the report and list of licensees and apprentices shall be filed in the office of the State Auditor, the Secretary of State, and Attorney General."

SECTION 5. G.S. 93D-5 reads as rewritten:

"**§ 93D-5. Requirements for ~~registration;~~licensure; examinations; apprentice licenses.**

(a) No person shall begin the fitting and selling of hearing aids in this State unless the person has been issued a license by the Board or is an apprentice working under the supervision of a licensee. Except as hereinafter provided, each applicant for a license shall pay a fee set by the Board, not to exceed one hundred fifty dollars ($150.00), and shall show to the satisfaction of the Board that the applicant:

(1) Is a person of good moral character,

(2) Is 18 years of age or older,

(3) Has an education equivalent to a four-year course in an accredited high school,

(4) Is free of contagious or infectious disease.

(b) Except as hereinafter provided, no license shall be issued to a person until ~~he~~the person has successfully passed a qualifying examination administered by the Board.

(c) No license shall be issued to any person until ~~he~~the person has served as an apprentice as set forth in G.S. 93D-9 for a period of at least one year; provided, that this subsection shall not apply to those persons qualified under G.S. 93D-6 nor to those persons holding ~~masters degrees~~a license in Audiology issued by the North Carolina Board of Examiners for Speech and Language Pathologist and Audiologist who have undergone 250 hours of supervised activity fitting and selling hearing aids under the direct supervision of a licensed hearing aid ~~dealer~~ dispenser approved by the Board, or have met the licensure requirements under Article 22 of Chapter 90 of the General Statutes and have worked full time for one year fitting and selling hearing aids in the office of and under the direct supervision of an otolaryngologist and have participated in 250 hours of Board-supervised, continuing professional education in fitting hearing aids."

SECTION 6. G.S. 93D-9 reads as rewritten:

"**§ 93D-9. Registration of apprentices.**

(a) Any person age ~~17~~ 18 or older may apply to the Board for registration as an apprentice. ~~Each applicant must be sponsored by a hearing aid dealer and fitter licensed by the Board.~~The Board may register an applicant as an apprentice if the applicant complies with all of the following:

(1) Is sponsored by a hearing aid dispenser licensed by the Board.

(2) Pays an application fee in an amount set by the Board, not to exceed one hundred dollars ($100.00).

(3) Successfully passes a Board approved prequalifying examination within 30 days from the date of application.

(4) Shows to the satisfaction of the Board that the applicant will be supervised and trained by a hearing aid dispenser licensed by the Board.

(b) ~~Upon receiving an application accompanied by a fee in an amount set by the Board, not to exceed one hundred dollars ($100.00), the Board may register the applicant as an apprentice, which~~A registered apprentice shall be entitled~~entitle the applicant~~ to fit and sell hearing aids under the supervision of a holder of a regular license.

~~(c) No applicant shall be registered as an apprentice by the Board under this section unless the applicant shows to the satisfaction of the Board that the applicant is or will be supervised and trained by a hearing aid fitter and seller who holds a license.~~

(d) If a person 18 years of age or older who is registered as an apprentice under this section does not take the next succeeding examination given after a minimum of one full year of apprenticeship, the person's apprentice registration shall not be renewed, except for good cause shown to the satisfaction of the Board.

(e) If a person who is registered as an apprentice takes and fails to pass the next succeeding examination given after one full year of apprenticeship, the Board may renew the apprenticeship license for a period of time to end 30 days after the results of the examination given next after the date of renewal of said registration. The fee for renewal of apprenticeship registration shall be set by the Board at an amount not to exceed one hundred fifty dollars ($150.00).

(f) The Board shall adopt rules implementing initial and renewal registration of apprentices."

SECTION 7. This act becomes effective October 1, 2007, and applies to applications on or after that date.

HOUSE BILL 1577:
Amend Hearing Aid Dealers/Fitters Laws/Fees

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	July 24, 2007
Introduced by:	Rep. England	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 1577 amends Chapter 93 which regulates the selling and fitting of hearing aids in North Carolina by (1) renaming the Board; (2) requiring apprentices to be at least 18 years of age and pass a qualifying exam;(3) authorizing the Board to charge a fee for that exam, (4) and establishing criteria for mail order sales of hearing aids in North Carolina.

The proposed committee substitute removes provisions authorizing the Board to increase the ceiling on other approved fees and makes changes to the effective date.

CURRENT LAW: Persons fitting or selling hearing aids in North Carolina are required to be licensed by the North Carolina State Hearing Aid Dealers and Fitters Board (Board) or be an apprentice under the supervision of a licensee.

BILL ANALYSIS:

Section 1 renames the North Carolina State Hearing Aid Dealers and Fitters Board to the North Carolina State Hearing Aid Licensing Board (Board).

Section 2 makes technical and conforming changes within the Act.

Section 3 provides to sell, lease, or rent hearing aids to persons in North Carolina by mail order the following criteria must be satisfied:

- The seller must be licensed as a hearing aid dispenser.
- Consultation with respect to the fitting, selection, adapting of a hearing aid, or taking of ear impressions must be given to the consumer either in person or telephonically by a live person who is either a licensed dispenser or apprentice.
- The seller must comply with all medical evaluation requirements pursuant to 21 CFR §801.421.
- The seller must comply with all federal regulations and State rules regarding the hearing aid device.

Mail order includes catalog, direct mail, television, radio, the Internet, or any other mass media source.

Section 4 authorizes the Board to charge a fee of not more than $25 to supervise and administer qualifying examinations for applicants for apprenticeships. Section 4 also directs that refunds provided in subsection (c)(11)of G.S. 93D-3 shall be made within 90 days.

Section 5 makes conforming changes.

Section 6 requires applicants for apprenticeship must be at least 18 years of age (was 17) and pass a qualifying exam within 30 days from the date of application.

Section 7 makes the act effective October 1, 2007 and applies to applications for apprenticeship on or after that date.

EFFECTIVE DATE: This act becomes effective October 1, 2007.

H1577e2-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

HOUSE BILL 1738

Short Title:	Advisory Comm./Hosp. Infection Incidence.	(Public)
Sponsors:	Representatives Glazier, Alexander, Allen, Insko (Primary Sponsors); Faison and Harrison.	
Referred to:	Health, if favorable, Appropriations.	

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE ADVISORY COMMISSION ON HOSPITAL INFECTION CONTROL AND DISCLOSURE.

Whereas, the Centers for Disease Control and Prevention (CDC) reports that approximately 2,000,000 people annually become ill from hospital-acquired infections, called nosocomial infections, and about 90,000 people die each year from hospital-acquired infections; and

Whereas, the CDC reports that hospital-acquired infections add at least $5,000,000,000 annually to the nation's health care bill; and

Whereas, a Pennsylvania report on hospital-acquired infections found that 76% of the cost for treating infections in that state was billed to public health insurance; and

Whereas, the CDC reports that despite the risks associated with nosocomial infections, information on nosocomial infection rates is hard to obtain, even though basic data is compiled as hospitals monitor infections, particularly in intensive care units and following surgery; and

Whereas, the CDC estimates, based on voluntary reporting, that hospital-acquired infections have become America's leading cause of death from infectious disease;

Whereas, it is the intent of the General Assembly to enact a law requiring public disclosure of hospital-acquired infection incidence rates to become effective in 2009; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Advisory Commission on Hospital Infection Control and Disclosure (Advisory Commission). The purpose of the Advisory Commission is to prepare State agencies, hospitals, and the public for the reporting and public disclosure of hospital-acquired infection incidence rates as may be required by law for specific clinical procedures under the following categories:

(1) Class I surgical site infections.
(2) Ventilator-associated pneumonia.
(3) Central line-related bloodstream infections.

SECTION 1.(b) The Advisory Commission shall consist of 13 members appointed as follows:

(1) Four shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, as follows:
   a. One member who is a hospital infection control professional, as recommended by the North Carolina Hospital Association;
   b. One physician who is a member of the Society for Health Care Epidemiology, as recommended by the Society for Health Care Epidemiology;
   c. The Director of the Statewide Program for Infection Control and Epidemiology at the School of Medicine of the University of North Carolina at Chapel Hill; and
   d. One who is a member of the general public but who is neither a health care professional nor affiliated with a health care facility.
(2) Four shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, as follows:
   a. One physician who is a member of the Society for Health Care Epidemiology, as recommended by the Society for Health Care Epidemiology;
   b. One member who is a hospital infection control professional, as recommended by the North Carolina Hospital Association;
   c. The Director of the Duke Inspection Control Network, or the Director's designee; and
   d. One who is a member of the general public but who is neither a health care professional nor affiliated with a health care facility.
(3) Five shall be appointed by the Governor, as follows:
   a. A representative of the North Carolina Institute of Medicine, as recommended by the North Carolina Institute of Medicine;
   b. The Director of the NC Center for Hospital Quality and Patient Safety;
   c. The Director of the Consumer Protection Division of the Office of the NC Attorney General;
   d. The State Health Director; and
   e. The State Epidemiologist.

The Governor shall appoint the Chair of the Advisory Committee.

SECTION 1.(c) Subject to the approval of the Legislative Services Commission, the Advisory Commission may meet in the State Legislative Building or the Legislative Office Building. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist in the work of the

Advisory Commission. The Directors of Legislative Assistants for the House of Representatives and the Senate shall assign clerical staff to the Advisory Commission, and the expenses relating to the clerical employees shall be borne by the Advisory Commission. The Advisory Commission, while in the discharge of its official duties, may exercise all the powers provided under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet during a regular or extra session of the General Assembly, subject to the approval of the President Pro Tempore of the Senate and the Speaker of the House of Representatives. Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 138-5 or G.S. 138-6, as applicable.

SECTION 2.(a) The Advisory Commission shall be meaningfully involved in the development of all aspects of the methodology used for collecting, analyzing, and disclosing publicly the information on hospital-acquired infection incidence rates, including collection methods, formatting, and methods and means for release and dissemination.

SECTION 2.(b) The Advisory Commission shall develop a process to ensure that information and data on hospital-acquired infection incidence rates available for dissemination to the general public shall not be made available in any form unless the information and data have been reviewed, adjusted, and validated according to the following process:

(1) The entire methodology for collecting and analyzing the data shall be disclosed to all relevant organizations and to all hospitals and ambulatory surgical facilities that are the subject of any information to be made available to the public before any public disclosure of the information or data.

(2) Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability before any information is made available to the public.

(3) Comparisons among hospitals and freestanding ambulatory surgical facilities shall adjust for patient case mix and other relevant risk factors and control for provider peer groups, when appropriate.

(4) The limitations of the data sources and analytic methodologies used to develop comparative hospital and freestanding ambulatory surgical facility information shall be clearly identified and acknowledged, including the appropriate and inappropriate uses of the data.

(5) To the greatest extent possible, comparative hospital and freestanding ambulatory surgical facility information initiatives shall use standard-based norms derived from widely accepted provider-developed practice guidelines.

(6) Comparative hospital and freestanding ambulatory surgical facility information and other information that the statewide data processor or Department has compiled regarding the hospital or freestanding ambulatory surgical facility shall be shared with the hospital or freestanding ambulatory surgical facility under review prior to public

dissemination of the information, and the hospital or freestanding ambulatory surgical facility shall have 30 days to make corrections and to add helpful explanatory comments about the information before the publication.

(7) Safeguards shall be implemented to:

a. Protect against the unauthorized use or disclosure of hospital and freestanding ambulatory surgical facility information; and

b. Protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective hospital or freestanding ambulatory surgical facility data.

(8) A process to ensure the quality and accuracy of information reported by a hospital or freestanding ambulatory surgical facility under this section and its data collection, analysis, and dissemination methodologies are evaluated regularly.

(9) A process to ensure that only the most basic identifying information from submitted reports are used, and except as otherwise authorized by Article 11A of Chapter 131E of the General Statutes, information identifying a patient, employee, or licensed professional shall not be released.

SECTION 2.(c) The Advisory Commission shall establish standardized criteria and methods for data submitted to the statewide data processor under G.S. 131E-214.2.

SECTION 3.(a) The Advisory Commission shall submit an interim report on its activities to the General Assembly on or before May 1, 2008. The Advisory Commission shall submit its final report to the 2009 General Assembly upon its convening with recommendations and proposed legislation for requiring hospital-acquired infection incidence rates public disclosure. Upon submission of its final report, the Commission shall terminate.

SECTION 3.(b) It is the intent of the General Assembly to enact legislation before adjournment sine die of the 2009 General Assembly requiring hospitals to report and publicly disclose hospital-acquired infection incidence rates.

SECTION 4. The Legislative Services Officer shall allocate funds appropriated to the General Assembly for this purpose to implement this act.

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1738:
Advisory Comm./Hosp. Infection Incidence

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	July 24, 2007
Introduced by:	Reps. Glazier, Alexander, Allen, Insko	**Summary by:**	Shawn Parker Legislative Analyst
Version:	PCS to First Edition H1738-CSSQ-63		

SUMMARY: ***House Bill 1738 would establish the Advisory Commission on Hospital Infection Control and Disclosure to prepare State agencies, hospitals and the public for the reporting of hospital –acquired infection incidence rates.***

This act is effective when it becomes law.

BILL ANALYSIS: The bill provides that it is the intent of the General Assembly to enact legislation during the 2009-2010 General Assembly to require hospitals to report and publicly disclose hospital-acquired infection incidence rates.

House Bill 1738 establishes a 13 member Advisory Commission on Hospital Infection Control and Disclosure (Commission) to prepare State agencies, hospitals, and the public for the reporting and disclosure of hospital-acquired infection incidence rates for the following procedures: (1) Class I surgical site infections; (2) Ventilator-associated pneumonia; (3) Central line-related bloodstream infections.

The Commission is directed to be involved in the development of all aspects of the methodology used for collecting, analyzing, and disclosing information on incidence rates to the public. The Commission is directed to develop a process to ensure information and data on hospital-acquired infection incidence rates is reviewed and validated prior to being disseminated to the public. As part of this process the Commission shall include safeguards to be implemented to protect against unauthorized use, dissemination of invalid data, and identifying information.

The Commission shall provide an interim report to the General Assembly on or before May 1, 2008 and shall terminate upon submitting a final report to the 2009 General Assembly upon its convening. The final report shall include recommendations and proposed legislation.

The General Assembly upon the recommendation of the Speaker of the House shall appoint the following members:

- A hospital infection control professional recommended by the North Carolina Hospital Association;
- A physician who is a member of the Society for Health Care Epidemiology recommended by the Society;
- The Director of the Statewide Program for Infection Control and Epidemiology;
- A member of the general public that is not a health care professional or affiliated with a health care facility.

The General Assembly upon the recommendation of the President Pro Tempore of the Senate shall appoint the following members:

- A hospital infection control professional recommended by the North Carolina Hospital Association;
- A physician who is a member of the Society for Health Care Epidemiology recommended by the Society;
- The Director or designee of the Duke Inspection Control Network;
- A member of the general public that is not a health care professional or affiliated with a health care facility.

The Governor shall appoint the following members:

- A representative of the North Carolina Institute of Medicine;
- The Director of the NC Center for Hospital Quality and Patient Safety;
- The Director of the Consumer Protection Division of the Office of the North Carolina Attorney General;
- The State Health Director;
- The State Epidemiologist.

The Governor shall also appoint the Chair of the advisory Commission.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Nosocomial infections (infections occurring in a hospital or hospital like setting) occur as a result of high prevalence of pathogens, high prevalence of compromised hosts, and the efficient mechanisms of transmission from patient to patient. Transmission now is generally a consequence of either accidental or deliberate disregard of established protocols designed to minimize transmission between patients or from hospital workers to patients.

"[n]osocomial infections can be transmitted by all modes of transmission that occur in the community. However, direct person-to-person transmission between an infected patient, staff member, or visitor and noninfected patients; indirect transmission through equipment, supplies, and hospital procedures; and transmission through air are most common in hospitals."[1]

The CDC has made a concerted effort in studying this trend establishing the NNIS, National Nosocomial Infection Surveillance, which began in 1970 and as of 1999 had participation from 285 hospitals in 42 states.

As of 2006, at least 14 States have passed laws relating to the public disclosure of hospital-acquired infection incidence rates.

H1738e1-SMSQ-CSSQ-60

[1] Black, J.G. (1996). *Microbiology. Principles and Applications.* Third Edition. Prentice Hall. Upper Saddle River, New Jersey. pp. 436-443.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1738
PROPOSED SENATE COMMITTEE SUBSTITUTE H1738-CSSQ-63 [v.1]

7/24/2007 9:12:58 PM

Short Title: Advisory Comm./Hosp. Infection Incidence. (Public)

Sponsors:

Referred to:

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE ADVISORY COMMISSION ON HOSPITAL INFECTION CONTROL AND DISCLOSURE.

Whereas, the Centers for Disease Control and Prevention (CDC) reports that approximately 2,000,000 people annually become ill from hospital-acquired infections, called nosocomial infections, and about 90,000 people die each year from hospital-acquired infections; and

Whereas, the CDC reports that hospital-acquired infections add at least $5,000,000,000 annually to the nation's health care bill; and

Whereas, a Pennsylvania report on hospital-acquired infections found that 76% of the cost for treating infections in that state was billed to public health insurance; and

Whereas, the CDC reports that despite the risks associated with nosocomial infections, information on nosocomial infection rates is hard to obtain, even though basic data is compiled as hospitals monitor infections, particularly in intensive care units and following surgery; and

Whereas, the CDC estimates, based on voluntary reporting, that hospital-acquired infections have become America's leading cause of death from infectious disease;

Whereas, it is the intent of the General Assembly to enact a law requiring public disclosure of hospital-acquired infection incidence rates to become effective in 2010; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Advisory Commission on Hospital Infection Control and Disclosure (Advisory Commission). The purpose of the Advisory Commission is to prepare State agencies, hospitals, and the public for the reporting and public disclosure of hospital-acquired infection incidence rates as may be required by law for specific clinical procedures under the following categories:

(1) Class I surgical site infections.
(2) Ventilator-associated pneumonia.
(3) Central line-related bloodstream infections.

SECTION 1.(b) The Advisory Commission shall consist of 13 members appointed as follows:

(1) Four shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, as follows:
   a. One member who is a hospital infection control professional, as recommended by the North Carolina Hospital Association;
   b. One physician who is a member of the Society for Health Care Epidemiology, as recommended by the Society for Health Care Epidemiology;
   c. The Director of the Statewide Program for Infection Control and Epidemiology at the School of Medicine of the University of North Carolina at Chapel Hill; and
   d. One who is a member of the general public but who is neither a health care professional nor affiliated with a health care facility.

(2) Four shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, as follows:
   a. One physician who is a member of the Society for Health Care Epidemiology, as recommended by the Society for Health Care Epidemiology;
   b. One member who is a hospital infection control professional, as recommended by the North Carolina Hospital Association;
   c. The Director of the Duke Inspection Control Network, or the Director's designee; and
   d. One who is a member of the general public but who is neither a health care professional nor affiliated with a health care facility.

(3) Five shall be appointed by the Governor, as follows:
   a. A representative of the North Carolina Institute of Medicine, as recommended by the North Carolina Institute of Medicine;
   b. The Director of the NC Center for Hospital Quality and Patient Safety;
   c. The Director of the Consumer Protection Division of the Office of the NC Attorney General;
   d. The State Health Director; and
   e. The State Epidemiologist.

The Governor shall appoint the Chair of the Advisory Committee.

SECTION 1.(c) Subject to the approval of the Legislative Services Commission, the Advisory Commission may meet in the State Legislative Building or the Legislative Office Building. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist in the work of the

Advisory Commission. The Directors of Legislative Assistants for the House of Representatives and the Senate shall assign clerical staff to the Advisory Commission, and the expenses relating to the clerical employees shall be borne by the Advisory Commission. The Advisory Commission, while in the discharge of its official duties, may exercise all the powers provided under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet during a regular or extra session of the General Assembly, subject to the approval of the President Pro Tempore of the Senate and the Speaker of the House of Representatives. Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 138-5 or G.S. 138-6, as applicable.

SECTION 2.(a) The Advisory Commission shall be meaningfully involved in the development of all aspects of the methodology used for collecting, analyzing, and disclosing publicly the information on hospital-acquired infection incidence rates, including collection methods, formatting, and methods and means for release and dissemination.

SECTION 2.(b) The Advisory Commission shall develop a process to ensure that information and data on hospital-acquired infection incidence rates available for dissemination to the general public shall not be made available in any form unless the information and data have been reviewed, adjusted, and validated according to the following process:

(1) The entire methodology for collecting and analyzing the data shall be disclosed to all relevant organizations and to all hospitals and ambulatory surgical facilities that are the subject of any information to be made available to the public before any public disclosure of the information or data.

(2) Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability before any information is made available to the public.

(3) Comparisons among hospitals and freestanding ambulatory surgical facilities shall adjust for patient case mix and other relevant risk factors and control for provider peer groups, when appropriate.

(4) The limitations of the data sources and analytic methodologies used to develop comparative hospital and freestanding ambulatory surgical facility information shall be clearly identified and acknowledged, including the appropriate and inappropriate uses of the data.

(5) To the greatest extent possible, comparative hospital and freestanding ambulatory surgical facility information initiatives shall use standard-based norms derived from widely accepted provider-developed practice guidelines.

(6) Comparative hospital and freestanding ambulatory surgical facility information and other information that the statewide data processor or Department has compiled regarding the hospital or freestanding ambulatory surgical facility shall be shared with the hospital or freestanding ambulatory surgical facility under review prior to public

dissemination of the information, and the hospital or freestanding ambulatory surgical facility shall have 30 days to make corrections and to add helpful explanatory comments about the information before the publication.

(7) Safeguards shall be implemented to:

a. Protect against the unauthorized use or disclosure of hospital and freestanding ambulatory surgical facility information; and

b. Protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective hospital or freestanding ambulatory surgical facility data.

(8) A process to ensure the quality and accuracy of information reported by a hospital or freestanding ambulatory surgical facility under this section and its data collection, analysis, and dissemination methodologies are evaluated regularly.

(9) A process to ensure that only the most basic identifying information from submitted reports are used, and except as otherwise authorized by Article 11A of Chapter 131E of the General Statutes, information identifying a patient, employee, or licensed professional shall not be released.

SECTION 2.(c) The Advisory Commission shall establish standardized criteria and methods for data submitted to the statewide data processor under G.S. 131E-214.2.

SECTION 3.(a) The Advisory Commission shall submit an interim report on its activities to the General Assembly on or before May 1, 2008. The Advisory Commission shall submit its final report to the 2009 General Assembly upon its convening with recommendations and proposed legislation for requiring hospital-acquired infection incidence rates public disclosure. Upon submission of its final report, the Commission shall terminate.

SECTION 3.(b) It is the intent of the General Assembly to enact legislation before adjournment sine die of the 2009 General Assembly requiring hospitals to report and publicly disclose hospital-acquired infection incidence rates.

SECTION 4. The Legislative Services Officer shall allocate funds appropriated to the General Assembly for this purpose to implement this act.

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 1738
PROPOSED SENATE COMMITTEE SUBSTITUTE H1738-PCS30520-SQ-63

Short Title: Advisory Comm./Hosp. Infection Incidence. (Public)

Sponsors:

Referred to:

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE ADVISORY COMMISSION ON HOSPITAL INFECTION CONTROL AND DISCLOSURE.

Whereas, the Centers for Disease Control and Prevention (CDC) reports that approximately 2,000,000 people annually become ill from hospital-acquired infections, called nosocomial infections, and about 90,000 people die each year from hospital-acquired infections; and

Whereas, the CDC reports that hospital-acquired infections add at least $5,000,000,000 annually to the nation's health care bill; and

Whereas, a Pennsylvania report on hospital-acquired infections found that 76% of the cost for treating infections in that state was billed to public health insurance; and

Whereas, the CDC reports that despite the risks associated with nosocomial infections, information on nosocomial infection rates is hard to obtain, even though basic data is compiled as hospitals monitor infections, particularly in intensive care units and following surgery; and

Whereas, the CDC estimates, based on voluntary reporting, that hospital-acquired infections have become America's leading cause of death from infectious disease; and

Whereas, it is the intent of the General Assembly to enact a law requiring public disclosure of hospital-acquired infection incidence rates to become effective in 2010; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Advisory Commission on Hospital Infection Control and Disclosure (Advisory Commission). The purpose of the Advisory Commission is to prepare State agencies, hospitals, and the public for the reporting and public disclosure of hospital-acquired infection incidence rates as may be required by law for specific clinical procedures under the following categories:

(1) Class I surgical site infections.
(2) Ventilator-associated pneumonia.
(3) Central line-related bloodstream infections.

SECTION 1.(b) The Advisory Commission shall consist of 13 members appointed as follows:

(1) Four shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, as follows:
   a. One member who is a hospital infection control professional, as recommended by the North Carolina Hospital Association;
   b. One physician who is a member of the Society for Health Care Epidemiology, as recommended by the Society for Health Care Epidemiology;
   c. The Director of the Statewide Program for Infection Control and Epidemiology at the School of Medicine of the University of North Carolina at Chapel Hill; and
   d. One who is a member of the general public but who is neither a health care professional nor affiliated with a health care facility.

(2) Four shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, as follows:
   a. One physician who is a member of the Society for Health Care Epidemiology, as recommended by the Society for Health Care Epidemiology;
   b. One member who is a hospital infection control professional, as recommended by the North Carolina Hospital Association;
   c. The Director of the Duke Inspection Control Network, or the Director's designee; and
   d. One who is a member of the general public but who is neither a health care professional nor affiliated with a health care facility.

(3) Five shall be appointed by the Governor, as follows:
   a. A representative of the North Carolina Institute of Medicine, as recommended by the North Carolina Institute of Medicine;
   b. The Director of the NC Center for Hospital Quality and Patient Safety;
   c. The Director of the Consumer Protection Division of the Office of the NC Attorney General;
   d. The State Health Director; and
   e. The State Epidemiologist.

The Governor shall appoint the Chair of the Advisory Committee.

SECTION 1.(c) Subject to the approval of the Legislative Services Commission, the Advisory Commission may meet in the State Legislative Building or the Legislative Office Building. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist in the work of the

Advisory Commission. The Directors of Legislative Assistants for the House of Representatives and the Senate shall assign clerical staff to the Advisory Commission, and the expenses relating to the clerical employees shall be borne by the Advisory Commission. The Advisory Commission, while in the discharge of its official duties, may exercise all the powers provided under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet during a regular or extra session of the General Assembly, subject to the approval of the President Pro Tempore of the Senate and the Speaker of the House of Representatives. Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 138-5 or G.S. 138-6, as applicable.

SECTION 2.(a) The Advisory Commission shall be meaningfully involved in the development of all aspects of the methodology used for collecting, analyzing, and disclosing publicly the information on hospital-acquired infection incidence rates, including collection methods, formatting, and methods and means for release and dissemination.

SECTION 2.(b) The Advisory Commission shall develop a process to ensure that information and data on hospital-acquired infection incidence rates available for dissemination to the general public shall not be made available in any form unless the information and data have been reviewed, adjusted, and validated according to the following process:

(1) The entire methodology for collecting and analyzing the data shall be disclosed to all relevant organizations and to all hospitals and ambulatory surgical facilities that are the subject of any information to be made available to the public before any public disclosure of the information or data.

(2) Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability before any information is made available to the public.

(3) Comparisons among hospitals and freestanding ambulatory surgical facilities shall adjust for patient case mix and other relevant risk factors and control for provider peer groups, when appropriate.

(4) The limitations of the data sources and analytical methodologies used to develop comparative hospital and freestanding ambulatory surgical facility information shall be clearly identified and acknowledged, including the appropriate and inappropriate uses of the data.

(5) To the greatest extent possible, comparative hospital and freestanding ambulatory surgical facility information initiatives shall use standard-based norms derived from widely accepted provider-developed practice guidelines.

(6) Comparative hospital and freestanding ambulatory surgical facility information and other information that the statewide data processor or Department has compiled regarding the hospital or freestanding ambulatory surgical facility shall be shared with the hospital or freestanding ambulatory surgical facility under review prior to public

dissemination of the information, and the hospital or freestanding ambulatory surgical facility shall have 30 days to make corrections and to add helpful explanatory comments about the information before the publication.

(7) Safeguards shall be implemented to:

a. Protect against the unauthorized use or disclosure of hospital and freestanding ambulatory surgical facility information; and

b. Protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective hospital or freestanding ambulatory surgical facility data.

(8) A process to ensure the quality and accuracy of information reported by a hospital or freestanding ambulatory surgical facility under this section and its data collection, analysis, and dissemination methodologies are evaluated regularly.

(9) A process to ensure that only the most basic identifying information from submitted reports are used, and except as otherwise authorized by Article 11A of Chapter 131E of the General Statutes, information identifying a patient, employee, or licensed professional shall not be released.

SECTION 2.(c) The Advisory Commission shall establish standardized criteria and methods for data submitted to the statewide data processor under G.S. 131E-214.2.

SECTION 3.(a) The Advisory Commission shall submit an interim report on its activities to the General Assembly on or before May 1, 2008. The Advisory Commission shall submit its final report to the 2009 General Assembly upon its convening with recommendations and proposed legislation for requiring hospital-acquired infection incidence rates public disclosure. Upon submission of its final report, the Commission shall terminate.

SECTION 3.(b) It is the intent of the General Assembly to enact legislation before adjournment sine die of the 2009 General Assembly requiring hospitals to report and publicly disclose hospital-acquired infection incidence rates.

SECTION 4. The Legislative Services Officer shall allocate funds appropriated to the General Assembly for this purpose to implement this act.

SECTION 5. This act is effective when it becomes law.

SEVISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 25, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Stevens	nursing
Rebecca Troutman	NCACC
Ashley Walker	AARP
April Culver	Johnston Memorial Hospital
DAVID BARNES	Pozner Sprouse
Jon Nelson	NCAHCP
Shaneese Parsons	DHHS
[illegible]	DHHS
[illegible]	[illegible]
Barbara Conder	BBCGR
Joni Alley	BEGINNINGS
[illegible]	NCFB
[illegible]	NCDS & NCPTA

SEVISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 25, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Kalbacker	N.C. Board of Nursing
Christine Crouj	WakeMed
Dana Simpson	Smith Anderson
Kevin Leonard	NCSR
ANN LOKE	DUKE
J&J Mobley	GOC offices
Daniel Baum	Kennedy Covington
Evelyn Hawthorne	NCAHA; NCOTA
Jerry Cooper	NCAHA
Jane Royall	NC Family Policy Council
Jeff Horton	NCHAS

SEVISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 25, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mac Bordley	NC Soc. of Anesthesiologists
[illegible]	NCCA
Colin Jones	ACCHC - Doctor of the Day
[illegible]	NCAPP
Martin Pharr	DJJDP
Jennifer K Mahan	MHANC
[illegible]	[illegible]
Darlyne Menscer, MD	NCMS
Melanie Phelps	"
[illegible]	"
[illegible]	NAMI NC

SEVISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 25, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Janet Schaffner	NC Council
Sally Cameron	NC Psychological
Bob Zeglicki	NCPC
Harry Taylor	MWC
J Craig Lewis	UNC
Glenn S. Keith	NCGA Staff
Patricia D. Yancey	APPC NC/MOD

SEVISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 25, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ashley McMurray	Intern – Rep Insko
Andy Ellen	NCRMA

SENATE COMMITTEE ON HEALTH CARE

MINUTES
JUNE 4, 2008

The Senate Committee on Health Care met on June 4, 2008 in Room 544 of the Legislative Office Building. The meeting was called to order by Senator Purcell, Co-chair. There were four bills on the agenda (Attachment I), and the first discussed was Senate Bill 1662 DISAPPROVE NURSING FACILITY REQUIREMENTS RULE; it was noted there was an amendment (Attachment II) sent forth by Senator Forrester to change the word "Facility" to "Faculty" in the short title; amendment adopted. Senator Rand presented his bill. See Attachment III for bill summary. Senator Forrester moved a favorable report for the bill, as amended; motion carried.

The next bill on the agenda was Senate 1770 EXPAND MEDICAL EXAMINER JURISDICTION/FUNDS (Attachment IV), sponsored by Senator Nesbitt. He presented a Committee Substitute (Attachment V), and Senator Jones moved its adoption; motion carried. After explaining the bill (Attachment VI); Senator Foriest moved an unfavorable report for the original bill and a favorable report for the Committee Substitute and that the bill be re-referred to Appropriations; motion carried.

Next bill considered was Senate 2117 AMEND SUBSTANCE ABUSE PROFESSIONALS ACT (Attachment VII), sponsored by Senator Nesbitt. A Committee Substitute (Attachment VIII) was presented, and Senator Allran moved its adoption; motion carried. After explanation by Senator Nesbitt (Attachment IX), Senator Bingham moved an unfavorable report for the original bill and a favorable report for the Committee Substitute and a referral to Finance; motion carried.

Senator Bingham took over as Chair in order that Senator Purcell could present the Senate Committee Substitute for HB 724 (Attachment X) PUBLIC HEALTH TECHNICAL CHANGES. –AB. Shawn Parker explained the proposed Senate Committee Substitute entitled USE OF SSN ON CHILD SUPPORT COURT ORDERS.-AB (Attachment XI). Bill summary is included as Attachment XII. Senator Dorsett moved an unfavorable report for the original bill and a favorable report for the Senate Committee Substitute, with a title change; motion carried.

Respectfully submitted,

Becky Hedspeth

Becky Hedspeth, Committee Clerk

William R Purcell

Senator William Purcell, Co-Chair

Becky Hedspeth (Sen. Purcell)

From: Rebecca Wood (Sen. Purcell)
Sent: Monday, June 02, 2008 4:32 PM
To: Sen. Tony Rand; Sen. William Purcell; Sen. Martin Nesbitt; Rep. Bob England
Subject: CORRECTED! Health Care Meeting June 4, 2008 11 AM

Principal Clerk _____
Reading Clerk _____

Corrected: 6-2-2008

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 4, 2008	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 724	Public Health Technical Changes.-AB	Representative England, M.D.
SB 1662	Disapprove Nursing Facility Requirements Rule.	Senator Rand
SB 1733	Hospital Report Child Injuries.	Senator Purcell
SB 1770	Expand Medical Examiner Jurisdiction/Funds.	Senator Nesbitt, Jr.
SB 2117	Amend Substance Abuse Professionals Act.	Senator Nesbitt, Jr.

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

HEALTH CARE MEETING
AGENDA

June 4, 2008
Rm 544

HB 724	**Public Health Technical Changes.**	**Rep. England, MD**
SB 1662	**Disapprove Nursing Facility Requirements Rule**	**Sen. Rand**
SB 1770	**Expand Medical Examiner Jurisdiction/Funds**	**Sen. Nesbitt, Jr.**
SB 2117	**Amend Substance Abuse Professionals Act**	**Sen. Nesbitt, Jr.**

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1662

Short Title:	Disapprove Nursing Facility Requirements Rule.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO DISAPPROVE A RULE ADOPTED BY THE NORTH CAROLINA BOARD OF NURSING AND APPROVED BY THE RULES REVIEW COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. Pursuant to G.S. 150B-21.3(b1), 21 NCAC 36 .0318 (Faculty), as adopted by the North Carolina Board of Nursing on May 18, 2007, and approved by the Rules Review Commission on June 28, 2007, is disapproved.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1662

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

S1662-ASQ-41 [v.1]

Date _____,2008

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Senator Purcell

moves to amend the bill by rewriting the short title to read:
"Disapprove Nursing Faculty Requirements Rule".

SIGNED Forrester
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 1662:
Disapprove Nursing Facility Requirements Rule

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 4, 2008
Introduced by:	Sen. Rand	**Summary by:**	Shawn Parker
Version:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 1662 disapproves 21 NCAC 36.0318 as adopted by the North Carolina Board of Nursing on May 18, 2007, and approved by the Rule Review Commission on June 28, 2007.

The rule governs nursing faculty requirements.

Rule Analysis:

If effective the rule would require nursing faculty who teach in programs leading to initial licensure and are initially employed after December 31, 2014 to have either a master's degree or a nursing doctorate degree from an accredited institution.

The rule allows the Board, upon request of a program, to waive this requirement for up to five years for instructors who have earned a baccalaureate degree in nursing.

CURRENT LAW:

The Administrative Procedures Act, Chapter 150B of the North Carolina General Statutes, provides permanent rules approved by the Rules Review Commission become effective on the first day of the month following the month the rule is approved unless the Commission receives written objections from 10 or more people clearly requesting legislative review.

A rule cannot then become effective before the 31st legislative day of the next General Assembly. Prior to the 31st legislative day, any member may introduce a bill to disapprove the rule. Once a bill is introduced, the rule cannot become effective until an unfavorable action is taken on the bill or the General Assembly adjourns without ratifying the bill.

EFFECTIVE DATE: This act is effective when it becomes law.

S1662e1-SMSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1770*

Short Title:	Expand Medical Examiner Jurisdiction/Funds.	(Public)
Sponsors:	Senators Nesbitt, Malone, Boseman, Apodaca, Atwater, Jones, Brown, Dorsett, Hartsell, Jenkins, Preston, Rand, Kerr, Snow, Goss; and Queen.	
Referred to:	Health Care.	

May 21, 2008

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE JURISDICTION OF MEDICAL EXAMINERS TO INCLUDE DEATHS THAT OCCUR AT FACILITIES OPERATED BY OR ON BEHALF OF THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-383(a) reads as rewritten:

"**§ 130A-383. Medical examiner jurisdiction.**

(a) Upon the death of any person resulting from violence, poisoning, accident, suicide or homicide; occurring suddenly when the deceased had been in apparent good health or when unattended by a physician; occurring in a jail, prison, correctional institution or in police custody; occurring in any facility operated by, or on behalf of, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services; occurring pursuant to Article 19 of Chapter 15 of the General Statutes; or occurring under any suspicious, unusual or unnatural circumstance, the medical examiner of the county in which the body of the deceased is found shall be notified by a physician in attendance, hospital employee, law-enforcement officer, funeral home employee, emergency medical technician, relative or by any other person having suspicion of such a death. No person shall disturb the body at the scene of such a death until authorized by the medical examiner unless in the unavailability of the medical examiner it is determined by the appropriate law enforcement agency that the presence of the body at the scene would risk the integrity of the body or provide a hazard to the safety of others. For the limited purposes of this Part, expression of opinion that death has occurred may be made by a nurse, an emergency medical technician or any other competent person in the absence of a physician."

SECTION 2. There is appropriated from the General Fund to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services the sum of one hundred fifty-eight thousand three hundred fifty-one dollars ($158,351) in recurring funds for the 2008-2009 fiscal year to implement this act.

SECTION 3. This act becomes effective July 1, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1770*
PROPOSED COMMITTEE SUBSTITUTE S1770-CSSQ-72 [v.1]

6/2/2008 12:50:46 PM

Short Title: Expand Medical Examiner Jurisdiction/Funds. (Public)

Sponsors:

Referred to:

May 21, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ALL DEATHS OCCURRING IN CERTAIN STATE FACILITIES BE REPORTED AND TO EXPAND THE JURISDICTION OF MEDICAL EXAMINERS TO INCLUDE THESE DEATHS AND TO APPROPRIATE FUNDS FOR IMPLEMENTATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-31 is amended by adding the following subsection to read:

"**§122C-31. Report required upon death of client.**

...

(g) In addition to the reporting requirements specified in subsections (a) through (e) of this section, and pursuant to G.S. 130A-383, every State facility shall report the death of any client of the facility, regardless of the manner of death, to the medical examiner of the county in which the body of the deceased is found."

SECTION 2. G.S. 130A-383(a) reads as rewritten:

"**§ 130A-383. Medical examiner jurisdiction.**

(a) Upon the death of any person resulting from violence, poisoning, accident, suicide or homicide; occurring suddenly when the deceased had been in apparent good health or when unattended by a physician; occurring in a jail, prison, correctional institution or in police ~~custody;~~custody; State facilities operated in accordance with Part 5 of Article 4 of Chapter 122C of the General Statutes; occurring pursuant to Article 19 of Chapter 15 of the General Statutes; or occurring under any suspicious, unusual or unnatural circumstance, the medical examiner of the county in which the body of the deceased is found shall be notified by a physician in attendance, hospital employee, law-enforcement officer, funeral home employee, emergency medical technician, relative or by any other person having suspicion of such a death. No person shall disturb the body at the scene of such a death until authorized by the medical examiner unless in the unavailability of the medical examiner it is determined by the appropriate law

enforcement agency that the presence of the body at the scene would risk the integrity of the body or provide a hazard to the safety of others. For the limited purposes of this Part, expression of opinion that death has occurred may be made by a nurse, an emergency medical technician or any other competent person in the absence of a physician."

SECTION 3. There is appropriated from the General Fund to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services the sum of one hundred fifty-eight thousand three hundred fifty-one dollars ($158,351) in recurring funds for the 2008-2009 fiscal year to implement this act.

SECTION 4. This act becomes effective July 1, 2008.

SENATE BILL 1770: Report All Deaths/Expand Medical Examiner Jurisdiction/Funds

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 3, 2008
Introduced by:	Sen. Nesbitt	**Summary by:**	Shawn Parker Legislative Analyst
Version:	PCS to First Edition S1770-CSSQ		

SUMMARY: Senate Bill 1770 would require that all deaths occurring in State institutions be reported to the local medical examiner; expands the jurisdiction of medical examiners to include deaths that occur in these facilities, and appropriates funds to cover associated costs with the increased investigatory requirements.

The proposed committee substitute adds the requirement that the Secretary must report all deaths that occur in State Facilities and clarifies the facilities are those listed in Part 5 of Article 4 in Chapter 122C of the General Statutes.

CURRENT LAW:

State facilities are required to notify the Secretary immediately upon the death of a client that occurs within seven days of physical restraint or seclusion, and to notify the Secretary within three days of any death resulting from violence, accident, suicide, or homicide.[1]

Upon the death of any person resulting from violence, poisoning, accident, suicide or homicide, or occurring in under suspicious, unusual, or unnatural circumstance, or occurring in certain circumstances (police custody, in jail, correctional institution) the medical examiner in the county in which the body is found must be notified.[2]

BILL ANALYSIS:

The bill requires all deaths that occur in the following State facilities be reported for further investigation:

(1) Psychiatric Hospitals:
- Cherry Hospital.
- Central Regional Hospital.
- Dorothea Dix Hospital.
- John Umstead Hospital.
- Broughton Hospital.

(2) Developmental Centers:
- Caswell Developmental Center.
- J. Iverson Riddle Developmental Center.
- Murdoch Developmental Center.

(3) Alcohol and Drug Treatment Centers:
- Walter B. Jones Alcohol and Drug Abuse Treatment Center.
- Julian F. Keith Alcohol and Drug Abuse Treatment Center.
- R.J. Blackley Alcohol and Drug Treatment Center.

(4) Neuro-Medical Treatment Centers:
- Black Mountain Neuro-Medical Treatment Center.
- O'Berry Neuro-Medical Treatment Center.
- Longleaf Neuro-Medical Treatment Center.

(5) Residential Programs for Children:
- Whitaker School.
- Wright School.

[1] N.C.G.S. 122C-31
[2] N.C.G.S. 130A-383

The bill further expands the jurisdiction of medical examiners to include all deaths that occur in these facilities and appropriates one hundred fifty-eight thousand three hundred fifty one dollars ($158,351) to implement the act.

EFFECTIVE DATE: This act becomes effective July 1, 2008.

S1770e1-SMSQ-CSSQ

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 2117*

Short Title:	Amend Substance Abuse Professionals Act.	(Public)
Sponsors:	Senators Nesbitt; and Bingham.	
Referred to:	Health Care.	

May 28, 2008

A BILL TO BE ENTITLED

AN ACT TO MAKE CERTAIN CLARIFYING CHANGES TO THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE ACT, TO CLARIFY THE REQUIREMENTS OF MEMBERSHIP ON THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD UNDER CERTAIN CIRCUMSTANCES, AND TO AMEND THE LAWS REQUIRING A PASSING SCORE ON AN ORAL EXAMINATION THEREBY AFFECTING FEES CHARGED BY THE BOARD UNDER THE LAWS REGULATING SUBSTANCE ABUSE PROFESSIONALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-113.31A reads as rewritten:

"**§ 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~~ Provisional licensed clinical addictions ~~specialist intern.~~specialist. – A ~~person~~ registrant 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 lifestyles 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~~ registrant 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,~~provisional licensed clinical addictions specialist, licensed clinical addictions specialist, certified substance abuse residential facility director, or certified criminal justice addictions professional."

SECTION 2. G.S. 90-113.32 reads as rewritten:

"**§ 90-113.32. Board; composition; voting.**

(a) The Board is created as the authority 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 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 credentialed pursuant to this Article and 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 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 ~~the North Carolina Substance Abuse Single State Agency,~~Community Policy Management of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, at least one of whom 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 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 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, that member may fulfill the remainder of his or her term on the Board."

SECTION 3. G.S. 90-113.40 reads as rewritten:

"**§ 90-113.40. Requirements for 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 to 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, has provided a Board-approved supervision contract between the applicant and an 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 a total of 6,000 hours of supervised experience in the field, whether paid or volunteer. The applicant for substance abuse prevention consultant has completed a total of 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 obtained a passing score on a written 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 (5a) of this section,~~if 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~~Submits 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.~~as a substance abuse clinical supervisor as documented by his or her certified clinical supervisor.

(4) Has 30 hours of substance abuse clinical supervision specific education or training. These hours shall be reflective of the Twelve Core Functions in the applicant's clinical application and practice and may also be counted toward the applicant's renewal as a substance abuse counselor or a clinical addictions specialist.

(5) Submits a letter of reference from a ~~professional~~ certified clinical supervisor 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.

(6) 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 (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 credentialing as a ~~certified substance abuse counselor, a~~ licensed clinical addictions ~~specialist, or certification or licensure through an organization granted deemed status by the Board.~~specialist.

(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 license credentialing an applicant as a "Licensed Clinical Addictions Specialist" if, in addition to meeting the requirements of subdivisions (a)(1) through (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 licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

d. Has achieved a ~~combined~~ passing 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 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 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 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~~a master's level written examination administered by the Board.
d. Submits three letters of reference from 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 Residential Facility Director" if the applicant:
(1) Has been 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 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 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)."

SECTION 4. G.S. 90-113.43 reads as rewritten:

"**§ 90-113.43. Illegal practice; misdemeanor penalty.**

Except as otherwise authorized in this Article, no person shall:

(1) 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 or~~ licensed clinical addictions specialist, ~~clinical addictions specialist intern,~~provisional licensed clinical addictions specialist, substance abuse residential facility director, certified criminal justice addictions professional, clinical supervisor intern, ~~substance abuse prevention consultant,~~substance abuse counselor intern, or registrant without first having obtained a ~~certificate~~ notification of 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 registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, substance abuse counselor intern, or ~~clinical addictions specialist intern~~provisional licensed clinical addictions specialist unless this person is 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, licensed clinical addictions specialist, certified criminal justice addictions professional, or certified substance abuse residential facility director with a revoked, lapsed, or suspended certification or license.

(4) Aid, abet, or assist any person to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, registrant, substance abuse counselor intern, provisional licensed 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, licensed clinical addictions specialist, certified substance abuse residential facility director, substance abuse counselor intern, provisional licensed clinical addictions ~~specialist intern,~~specialist, or clinical supervisor intern unless that person is 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 or provisional licensed clinical addictions specialist 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."

SECTION 5. G.S. 122C-142.1(b1) reads as rewritten:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

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

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

(3) (Repealed effective October 1, 2008. See note.) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM).

(6) A Certified Criminal Justice Addictions Professional, as certified by the North Carolina Substance Abuse Professional Practice Board.

(7) A Provisional Licensed Clinical Addictions Specialist, as registered by the North Carolina Substance Abuse Professional Practice Board."

SECTION 6. G.S. 122C-142.1(d1) reads as rewritten:

"(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.

(4) Certified Criminal Justice Addictions Professional, as certified by the North Carolina Substance Abuse Professional Practice Board.

(5) Provisional Licensed Clinical Addictions Specialist, as registered by the North Carolina Substance Abuse Professional Practice Board."

SECTION 7. Notwithstanding G.S. 90-113.32(e), members currently serving on the North Carolina Substance Abuse Professional Practice Board who began serving a second consecutive four-year term as of September 1, 2005, may continue to serve on the Board for an additional four-year term.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S Nesbitt D

SENATE BILL 2117*
PROPOSED COMMITTEE SUBSTITUTE S2117-CSRD-50 [v.1]

6/3/2008 5:04:51 PM

Short Title: Amend Substance Abuse Professionals Act. (Public)

Sponsors:

Referred to:

May 28, 2008

A BILL TO BE ENTITLED

AN ACT TO MAKE CERTAIN CLARIFYING CHANGES TO THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE ACT, TO CLARIFY THE REQUIREMENTS OF MEMBERSHIP ON THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD UNDER CERTAIN CIRCUMSTANCES, AND TO AMEND THE LAWS REQUIRING A PASSING SCORE ON AN ORAL EXAMINATION THEREBY AFFECTING FEES CHARGED BY THE BOARD UNDER THE LAWS REGULATING SUBSTANCE ABUSE PROFESSIONALS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-113.31A reads as rewritten:

"**§ 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 lifestyles and environments.

(22) Professional discipline. – A field of study characterized by the technical, educational, and ethical standards of a profession.

(22a) Provisional licensed clinical addictions specialist. – A registrant who successfully completes 300 hours of Board-approved supervised practical training in pursuit of licensure as a clinical addictions specialist.

(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~~ registrant 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,~~provisional licensed clinical addictions specialist, licensed clinical addictions specialist, certified substance abuse residential facility director, clinical supervisor intern, or certified criminal justice addictions professional."

SECTION 2. G.S. 90-113.32 reads as rewritten:

"**§ 90-113.32. Board; composition; voting.**

(a) The Board is created as the authority 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 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 credentialed pursuant to this Article and 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 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 ~~the North Carolina Substance Abuse Single State Agency,~~Community Policy Management of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, at least one of whom 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 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 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, that member may fulfill the remainder of his or her term on the Board."

SECTION 3. G.S. 90-113.40 reads as rewritten:

"**§ 90-113.40. Requirements for 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 to 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, has provided a Board-approved supervision contract between the applicant and an 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 a total of 6,000 hours of supervised experience in the field, whether paid or volunteer. The applicant for substance abuse prevention consultant has completed a total of 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 obtained a passing score on a written 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 (5a) of this section,~~if 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~~Submits 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.~~as a substance abuse clinical supervisor as documented by his or her certified clinical supervisor.

(4) Has 30 hours of substance abuse clinical supervision specific education or training. These hours shall be reflective of the Twelve Core Functions in the applicant's clinical application and practice and may also be counted toward the applicant's renewal as a substance abuse counselor or a clinical addictions specialist.

(5) Submits a letter of reference from a ~~professional~~ certified clinical supervisor 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.

(6) 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 (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 credentialing as a ~~certified substance abuse counselor, a~~ licensed clinical addictions ~~specialist, or certification or licensure through an organization granted deemed status by the Board.~~specialist.

(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 license credentialing an applicant as a "Licensed Clinical Addictions Specialist" if, in addition to meeting the requirements of subdivisions (a)(1) through (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 licensed clinical addictions specialists or certified substance abuse counselors who have obtained master's degrees.

d. Has achieved a ~~combined~~ passing 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 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 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 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~~a master's level written examination administered by the Board.

d. Submits three letters of reference from 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 Residential Facility Director" if the applicant:

(1) Has been 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 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 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)."

SECTION 4. G.S. 90-113.42 reads as rewritten:

"**§ 90-113.42. 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.

(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 registered, certified, or licensed under this Article may use the title "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", "Provisional Licensed

Clinical Addictions ~~Specialist Intern".~~ Specialist", "Clinical Supervisor Intern", or "Registrant"."

SECTION 5. G.S. 90-113.43 reads as rewritten:

"**§ 90-113.43. Illegal practice; misdemeanor penalty.**

(a) Except as otherwise authorized in this Article, no person shall:

(1) 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 or~~ licensed clinical addictions specialist, ~~clinical addictions specialist intern,~~provisional licensed clinical addictions specialist, certified substance abuse residential facility director, certified criminal justice addictions professional, clinical supervisor intern, ~~substance abuse prevention consultant,~~substance abuse counselor intern, or registrant without first having obtained a ~~certificate~~ notification of 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 registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, substance abuse counselor intern, certified criminal justice addictions professional, or ~~clinical addictions specialist intern~~provisional licensed clinical addictions specialist unless this person is 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, licensed clinical addictions specialist, certified criminal justice addictions professional, substance abuse counselor intern, provisional licensed clinical addictions specialist, clinical supervisor intern, ~~or~~ certified substance abuse residential facility director or registrant with a revoked, lapsed, or suspended certification or license.

(4) Aid, abet, or assist any person to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, registrant, substance abuse counselor intern, provisional licensed 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 criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse

residential facility director, substance abuse counselor intern, provisional licensed clinical addictions ~~specialist intern,~~specialist, or clinical supervisor intern unless that person is 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.~~

(b) 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."

SECTION 6. G.S. 122C-142.1(b1) reads as rewritten:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

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

(2) A ~~Certified~~ Licensed Clinical Addiction Specialist ~~(CCAS), (LCAS),~~ as defined by the Commission.

(3) (Repealed effective October 1, 2008. See note.) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM).

(6) A Provisional Licensed Clinical Addictions Specialist, as registered by the North Carolina Substance Abuse Professional Practice Board."

SECTION 7. G.S. 122C-142.1(d1) reads as rewritten:

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

(2) A ~~Certified~~ Licensed Clinical ~~Addiction~~ Addictions Specialist ~~(CCAS),~~ (LCAS), as defined by the Commission.

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

(4) A Provisional Licensed Clinical Addictions Specialist, as registered by the North Carolina Substance Abuse Professional Practice Board."

SECTION 8. Notwithstanding G.S. 90-113.32(e), members currently serving on the North Carolina Substance Abuse Professional Practice Board who began

serving a second consecutive four-year term as of September 1, 2005, may continue to serve on the Board for an additional four-year term.

SECTION 9. This act is effective when it becomes law.

SENATE BILL 2117:
Amend Substance Abuse Professionals Act

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	June 3, 2008
Introduced by:	Sen. Nesbitt	**Summary by:**	Ben Popkin Committee Counsel
Version:	PCS to First Edition S2117-CSRD		

SUMMARY: ***Senate Bill 2117 would make the following changes to the North Carolina Substance Abuse Professionals Practice Act: update terminology and delete outdated provisions, shorten the application process for Licensed Clinical Addictions Specialists by eliminating the currently required 2,000 hours of post-masters' degree supervised work, allow provisional licensees to conduct DWI assessments and provide ADET school instruction, and reduce the time and cost of credentialing by eliminating the oral examination component of the certifying examinations.***

[As introduced, this bill was identical to H2746, as introduced by Rep. M. Alexander, which is currently in House Finance.]

BILL ANALYSIS:

Section 1 of Senate Bill 2117 would revise the definition of "Clinical addictions specialist interns" to reflect their new title as "Provisional licensed clinical addictions specialists" and insert the definition into the existing definition section of the Practice Act in the appropriate alphabetical location. This section would also remove the requirement that substance abuse counselor interns pass a written examination from its definition. The definition of "substance abuse professional" would be revised to reflect the new "Provisional licensed..." title and add clinical supervisor interns to the definition.

Section 2 of Senate Bill 2117 would delete an outdated provision addressing appointment of the original Board (G.S. 90-113.32(b)) and would revise G.S. 90-113.32(c)(3) to specify that two members of DHHS may be appointed to the Board by the "Chief of Community Policy Management of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services".

Section 3 of Senate Bill 2117 would modify existing certification and licensure requirements as follows:

- Eliminate the oral examination component for certification as a "Certified Substance Abuse Counselor".
- Streamline certification requirements for "Certified Clinical Supervisors" by deleting outdated provisions, removing the requirements that apply to non-masters' degree candidates (all must now have masters' degrees), to now require 4,000 hours as a "substance abuse clinical supervisor" and a letter of reference from a certified clinical supervisor.
- Revise requirements for "Clinical Supervisor Interns" specifying that applicants be credentialed as "Licensed Clinical Addictions Specialists".
- Remove the oral examination component for applicants as "Licensed Clinical Addictions Specialists" and remove the one year of postgraduate supervised substance abuse counseling experience required of applicants pursuing the "Criteria B" avenue toward licensure.

Section 4 of Senate Bill 2117 would revise the reference to "Clinical addictions specialist interns" to reflect their new title as "Provisional licensed clinical addictions specialists".

Section 5 of Senate Bill 2117 would update the titles of substance abuse practitioners included in G.S. 90-113.43, barring unqualified persons from practicing as, holding themselves out as, etc. qualified substance abuse practitioners and would delete obsolete language.

Sections 6 and 7 of Senate Bill 2117 would revise the statutes to authorize "Licensed Clinical Addictions Specialists" to conduct substance abuse assessments and provide ADET school instruction as Department authorized ADETS instructors.

Section 8 of Senate Bill 2117 would allow Board members serving a second term as of September 1, 2005 to continue to serve on the Board for an additional term.

Section 9 of Senate Bill 2117 sets forth the effective date.

EFFECTIVE DATE: This act is effective when it becomes law.

S2117e1-SMRD-CSRD

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 724*
Committee Substitute Favorable 4/18/07

Short Title: Public Health Technical Changes.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND OTHER CHANGES IN THE PUBLIC HEALTH LAW RELATED TO THE MEDICAL EXAMINER SYSTEM, INJURY CONTROL EFFORTS, TIMELINESS OF REPORTS BY SCHOOLS REGARDING IMMUNIZATIONS, AND THE CREATION, EXTENSION, AND DISSOLUTION OF SANITARY DISTRICTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-47 reads as rewritten:

"**§ 130A-47. Creation by Commission.**

(a) For the purpose of preserving and promoting the public health and welfare, the Commission may create sanitary districts without regard for county, township or municipal lines. However, no municipal corporation or any part of the territory in a municipal corporation shall be included in a sanitary district except at the request of the governing board of the municipal corporation. If the municipal corporation has not levied any tax nor performed any official act nor held any elections within a period of four years preceding the date of the petition for the sanitary district, a request of the governing board shall not be required.

(b) For the purposes of this Part, the term 'Department' means the Department of Environment and Natural Resources, and the term 'Secretary' means the Secretary of Environment and Natural Resources."

SECTION 2. G.S. 130A-155(c) reads as rewritten:

"(c) ~~Within 60 calendar days after the commencement of a new school year, the~~ The school shall file an annual immunization report with the ~~Department.~~Department by November 1. The child care facility shall file an immunization report annually with the Department. The report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the number of children who received a medical exemption and the number of children who received a religious exemption."

SECTION 3. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 6. Injury Prevention.

"§ 130A-224. Department to establish program.

To protect and enhance the public health, welfare, and safety, the Department shall establish and administer a comprehensive statewide injury prevention program. The Department shall designate the Division of Public Health as the lead agency for injury prevention activities. The Division of Public Health shall:

(1) Develop a comprehensive State plan for injury prevention;

(2) Maintain an injury prevention program that includes data collection, surveillance, and education and promotes injury control activities; and

(3) Develop collaborative relationships with other State agencies and private and community organizations to establish programs promoting injury prevention."

SECTION 4. G.S. 130A-382 reads as rewritten:

"§ 130A-382. County medical examiners; appointment; term of office; vacancies.

One or more county medical examiners for each county shall be appointed by the Chief Medical Examiner for a three-year term. County medical examiners shall be appointed from a list of physicians licensed to practice medicine in this State submitted by the medical society of the county in which the appointment is to be made. If no names are submitted by the society, the Chief Medical Examiner shall appoint one or more medical examiners from physicians in the county licensed to practice medicine in this State. In the event no licensed physician in a county accepts an appointment, the Chief Medical Examiner may appoint as acting county medical examiner one or more physicians licensed to practice medicine in this State from other ~~counties or the local registrar, deputy registrar, subregistrar or coroner.~~counties, a licensed physician assistant, a nurse, a coroner, or an individual who has taken an approved course of training as required by the Chief Medical Examiner. ~~In the event a medical examiner is unable to serve in a particular case or for a temporary period of time, the Chief Medical Examiner shall designate a physician licensed to practice medicine in this State, the local registrar, deputy registrar, subregistrar or coroner~~ The acting county medical examiner shall have all the duties and authority of the physician medical examiner except to perform autopsies. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so."

SECTION 5. G.S. 130A-381 reads as rewritten:

"§ 130A-381. Additional services and facilities.

In order to provide proper facilities for investigating deaths as authorized in this Part, the Chief Medical Examiner may arrange for the use of existing public or private laboratory facilities. Each county shall provide or contract for an appropriate facility for the examination and storage of bodies under Medical Examiner jurisdiction. The Chief Medical Examiner may contract with qualified persons to perform or to provide support services for autopsies and other studies and investigations."

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 724*

Committee Substitute Favorable 4/18/07

PROPOSED SENATE COMMITTEE SUBSTITUTE H724-CSSQ-73 [v.1]

6/2/2008 2:11:36 PM

Short Title: Use of SSN on Child Support Court Orders.-AB (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO NO LONGER REQUIRE THE USE OF SOCIAL SECURITY NUMBERS ON NORTH CAROLINA CHILD SUPPORT COURT ORDERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 50-13.4 reads as rewritten:

"**§ 50-13.4. Action for support of minor child.**

...

(g) An individual who brings an action or motion in the cause for the support of a minor child, and the individual who defends the action, shall provide to the clerk of the court in which the action is brought or the order is issued, the individual's social security number. ~~The child support order shall contain the social security number of the parties as evidenced in the support proceeding.~~

(h) Child support orders initially entered or modified on and after October 1, 1998, shall contain the name of each of the parties, the date of birth of each ~~party, the social security number of each party,~~party, and the court docket number. The Administrative Office of the Courts shall transmit to the Department of Health and Human Services, Child Support Enforcement Program, on a timely basis, the information required to be included on orders under this ~~subsection.~~subsection and the social security number of each party as required under subparagraph (g)."

SECTION 2. This act is effective October 1, 2008.

HOUSE BILL 724:
Use of SSN on Child Support Court Orders.-AB

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 3, 2008
Introduced by:	Rep. England	**Summary by:**	Shawn Parker
Version:	PCS to Second Edition H724-CSSQ-73		Legislative Analyst

SUMMARY: ***The Proposed Senate Committee Substitute for House Bill 724 completely rewrites the original bill. HB724 eliminates the use of social security numbers on North Carolina child support court orders.***

[As introduced, this bill was identical to S583, as introduced by Sen. Purcell, which became S.L. 2007-187.]

CURRENT LAW:

North Carolina requires that both parents' social security numbers be included on a child support court order.[1] A copy is provided to each parent and the court order is a public document.

BILL ANALYSIS:

House Bill 724 amends NCGS 50-13.4 by removing the requirement that a child support order contain the social security number of the parties.

EFFECTIVE DATE: The act would become effective October 1, 2008.

BACKGROUND:

Child Support Enforcement has eliminated the use of social security number as an identifier on all other public documents except for the child support court order which must be included per existing statutory requirements.

If enacted, the social security number of each party will still be collected and stored to be used if necessary for the purpose of locating an absent parent or wage garnishment.

H0724e2-SMSQ-CSSQ-73

[1] N.C.G.S 50-13.4(g) and N.C.G.S. 50-13.4(h)

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, June 05, 2008

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

FAVORABLE, AS AMENDED

S.B. **1662** Disapprove Nursing Facility Requirements Rule.

Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

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

S.B. **1770** Expand Medical Examiner Jurisdiction/Funds.

Draft Number:	15292
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

S.B. **2117** Amend Substance Abuse Professionals Act.

Draft Number:	65389
Sequential Referral:	Finance
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) **724** Public Health Technical Changes.-AB

Draft Number:	10458
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

SENATE HEALTH CARE COMMITTEE
Wednesday, June 11, 2008 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 11, 2008, in Room 544 of the Legislative Office Building, with fourteen members present. Senator Stan Bingham presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham recognized Representative Clary to present House Bill 964, ***Expand Definition of Home Care Services***, and also asked for a motion to hear the Proposed Committee Substitute. Senator Jones offered the motion, which passed. Rep. Clary asked staff to explain the bill. Shawn Parker explained that House Bill 964 increased the annual license fee for Home Care Agencies from $350.00 to $400.00. Also he stated it expanded the definitions of home care services in the statutes to include in-home companion, sitter, respite care services provided to an individual, and home-maker services provided in combination with in-home companion, sitter, and respite or other home care services. Rep. Clary stated that everybody involved had signed off on the legislation. Senator Bingham pointed out that House Bill 964 had a Sequential Referral to Finance. Senator Jones offered a motion Unfavorable as to Bill, but Favorable as to Committee Substitute Bill, that passed unanimously.

Senator Bingham asked for a motion to hear the Proposed Committee Substitute for Senate Bill 1669, ***Community Colleges/Tobacco Free***. Senator Malone offered the motion, which carried. Senator Purcell was asked to explain the bill and he stated the bill came from the Justus-Warren Heart Disease and Stroke Prevention Task Force. Senator Purcell pointed out that local community college boards of trustees were granted the authority to prohibit smoking in their buildings and on campuses in 2005, but in 2007 S.L. 2007-193 unintentionally limited the authority of the community colleges, as a local government agency, to regulate smoking on their grounds. Senate Bill 1669 gives local community college boards of trustees clear authority to adopt and implement a tobacco free policy for the buildings, grounds, and college sponsored events. In 2006 the Surgeon General's Report stated there was no safe level of exposure to second hand smoke. Senator Blake asked if the bill that was passed two years ago had had any positive effects and could they actually control the smoking and chewing of tobacco on high school campuses. Pam Seamans, NC Alliance for Health, stated that the tobacco free school bill that passed last year had led to almost 100% of the school systems in the state passing 100% tobacco free policies in their schools, with only three school systems remaining that have not passed tobacco free policies. Mark Ezzell, Tobacco-Free Campus Director, stated that research had shown a 40% reduction in tobacco use. Senator Allran wanted to follow up that he had taught in Community Colleges and that there were no disciplinary problems because the students were there to learn. He stated that he knew Sen. Blake was referring to High Schools but pointed out this bill was for Community Colleges. Senator Allran moved for a favorable report. Ashley Bell, Director of Government

Relations for the American Cancer Society stated they are supportive of this bill and the two following bills. Senator Foriest wanted to exemplify his support of the bill stating the legislative body needs to take a lead in helping North Carolina to change its mind set on tobacco. He pointed out that North Carolina had relied on tobacco and tobacco money for many many years, and as a result of that sometimes eyes are closed to the ill effects of it. Now would be an opportunity to correct the health hazards that we have gotten over the past years. Sen. Jacumin stated he concurred with controlling the smoke inside the buildings but was very concerned when they go outside. He felt if people are outside, like the man mowing the ball fields, and wants to smoke he should have the right to. He pointed out that the smoke probably was a millionth of what was being put off with the lawn mower. Shawn Parker, Research, responded that Senate Bill 1669 only gives the Community College Board of Trustees the authority to adopt policies regulating tobacco use. Rep. Justice, a primary sponsor of the bill in the house, wanted to comment. She stated she was a cancer survivor and a student at a community college and would like for her community college to have the authority to have a smoke free environment. Senator Allran had already made the motion unfavorable as to bill, but favorable as to committee substitute bill. The vote was taken and the bill passed.

Senator Purcell was recognized to present Senate Bill 1681, ***Smoke-Free Motor Fleet***. Senator Purcell made the motion to hear the Proposed Committee Substitute, which passed. Senator Purcell pointed out there was a technical amendment to go with the bill. Ben Popkin, Research, explained the amendment would allow for renumbering of the definitions section in the statutes. Senator Malone made the motion to pass the amendment, which passed unanimously. Senator Purcell stated that Senate Bill 1681 also came from the Justus-Warren Heart Disease and Stroke Prevention Task Force. SB 1681 makes all state owned and operated passenger-carrying vehicles smoke free. Section Four will give local government the same opportunity. Again Senator Purcell stressed that the Surgeon General had said there was no safe level of exposure to second hand smoke. He also explained that there had been a real problem with the motor pool selling vehicles that have been operated by smokers. John Massey, Director of North Carolina Motor Fleet, stressed that there was a considerable problem with smoke residue left behind by smokers. Senator Brunstetter made a motion to roll the amendment into a new Proposed Committee Substitute, unfavorable as to original bill, but favorable as to the new Proposed Committee Substitute. The motion passed.

Senator Bingham asked for a motion to hear the Proposed Committee Substitute for Senate Bill 1686, ***Smoke-Free State and Local Building Grounds***. Senator Forrester offered the motion, which passed. Senator Purcell pointed out Senate Bill 1686 came from the Justus-Warren Heart Disease and Stroke Prevention Task Force. The bill required no smoking within fifty feet of state buildings if the ground was controlled by the state. Section two simply stated that local governments might do the same. Senator Forrester stated he felt the fifty feet was rather restrictive. He would rather it be twenty-five feet but will support the bill. Ashley Bell, Director of Government Relations for the American Cancer Society, stated that it only controls up to the public right-of-way, no one will have to go out into the street. Sen. Purcell added that in previous legislation social services and health departments have a fifty-feet limit on smoking at their

entrances. Pam Seams, North Carolina Alliance for Health, stated that the alliance supports this bill and the purpose for including the perimeter around the building was to protect the entrances so the smoke does not return back inside the building. Senator Nesbitt questioned the fifty feet, which does not state who owned the land. Senator Nesbitt asked to amend the bill. Senator Jacumin asked would it not be better to say fifty feet from any entrance to a building instead of enclosing the whole building, that way the smokers could stand in the shade of the building and take a smoke. Senator Purcell asked to allow Betsy Vetter with the American Heart Association to give her views. Ms. Vetter stated they do support all the tobacco bills and stated there were state government buildings that still have open windows and they are trying to protect the people in these buildings also. Senator Forrester stated he would like to move for a favorable report, unfavorable to original bill, but favorable as to the Proposed Committee Substitute. Senator Bingham stated they would displace Senate Bill 1686 until Senator Nesbitt's amendment was completed.

Senator Bingham asked for a motion to adopt the PCS for Senate Bill 1687, ***Establish Public Health Incubator Program***, for discussion. Senator Forrester made the motion, which passed. Senator Purcell stated the bill came out of the Public Health Study Commission. Senator Purcell pointed out that The Public Health Incubator Program was in operation in North Carolina right now, where local heath departments can combine activities and share with several health departments. Shawn Parker explained that this PCS actually directs that Public Health Incubator Programs to report by October 1, 2008 and then annually thereafter on their actives which are their primary mission to support voluntary local health department collaborative efforts. They report back to the Public Health Study Commission. Dr. John Graham, Deputy Director of the NC Institute for Public Health, was available to answer any questions. Senator Atwater and Senator Hartsell both made the motion, unfavorable to original bill, favorable to the proposed committee substitute, which passed.

Now Senator Bingham directed the meeting back to Senator Bill 1686, ***Smoke-Free State and Local Building Grounds***. Ben Popkins was asked to explain Senator Nesbitt's amendment, which deleted the word controlled and inserted words owned, leased as lesser, or leased as lessee. Senator Nesbitt made the motion to adopt the amendment. The amendment passed. Then the bill was brought back and Senator Forrester had previously made the motion, unfavorable to the original bill, but favorable to the committee substitute with the amendment included. The bill passed.

The meeting adjourned at 11:57 A.M.

Stan Bingham
Senator Stan Bingham, Co-Chair

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

Judy F. Chriscoe
Judy Chriscoe, Committee Assistant

Senate Health Care Committee
Wednesday, June 11, 2008, 11:00 AM
544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 1669	**Community Colleges/Tobacco Free.**	**Senator Purcell**
SB 1681	**Smoke-Free Motor Fleet.**	**Senator Purcell**
SB 1686	**Smoke-Free State and Local Bldg. Grounds.**	**Senator Purcell**
SB 1687	**Establish Public Health Incubator Program.**	**Senator Purcell**
HB 964	**Expand Definition of Home Care Services.**	**Representative Earle Representative Clary Representative Farmer-Butterfield**

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 11, 2008

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

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

S.B. **1687** Establish Public Health Incubator Program.

Draft Number:	55738
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 Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, June 12, 2008

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

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

S.B. **1681** Smoke-Free Motor Fleet.

Draft Number:	85473
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **1686** Smoke-Free State and Local Bldg. Grounds.

Draft Number:	75583
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

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 12, 2008

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

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

S.B. **1669** Community Colleges/Tobacco Free.

Draft Number:	15298
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **964** Expand Definition of Home Care Services.

Draft Number:	70782
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1669*

Short Title:	Community Colleges/Tobacco Free.	(Public)
Sponsors:	Senators Purcell, Dorsett, Forrester; McKissick, and Snow.	
Referred to:	Health Care.	

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO PROTECT COMMUNITY COLLEGE STUDENTS AND STAFF, AS WELL AS VISITING PUBLIC SCHOOL STUDENTS, FROM EXPOSURE TO TOBACCO BY AUTHORIZING LOCAL COMMUNITY COLLEGE BOARDS OF TRUSTEES TO ADOPT WRITTEN POLICIES PROHIBITING THE USE OF TOBACCO PRODUCTS IN BUILDINGS, IN COMMUNITY COLLEGE FACILITIES, ON COMMUNITY COLLEGE CAMPUSES, OR AT COMMUNITY COLLEGE-RELATED OR COMMUNITY COLLEGE-SPONSORED EVENTS, AND IN OR ON OTHER COMMUNITY COLLEGE PROPERTY, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

Whereas, young adults, ages 18-24, currently have the highest smoking prevalence in North Carolina; and

Whereas, in 2007, the General Assembly enacted Senate Bill 1086, an act requiring local boards of education to adopt, implement, and enforce written policies prohibiting at all times the use of any tobacco product by any person in school buildings; and

Whereas, evidence shows that students attending a North Carolina high school that had established 100% tobacco-free school policy were 32% less likely to be tobacco users and 40% less likely to be smokers compared to non-tobacco-free school districts; and

Whereas, many North Carolina high school students attend classes or other educational events at community colleges; and

Whereas, North Carolina's public high school students should be protected from exposure to tobacco on community college campuses and in classrooms as well as in public school buildings and campuses; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 115D of the General Statutes is amended by adding the following new section to read:

"§ 115D-25.4. Prohibition of tobacco use in community college buildings, grounds, and at community college-sponsored events.

(a) As used in this section:

(1) "Tobacco product" includes cigarettes, cigars, blunts, bidis, pipes, chewing tobacco, snus, snuff, and any other items containing or reasonably resembling tobacco or tobacco products.

(2) "Tobacco use" includes smoking, chewing, dipping, or any other use of tobacco products.

(b) Local community college boards may adopt, implement, and enforce a written policy prohibiting at all times the use of any tobacco product by any person in community college buildings, in community college facilities, on community college campuses, and in or on any other community college property owned, leased, or operated by the local community college. The policy may also prohibit the use of all tobacco products by persons attending a community college-sponsored event at a location not listed in this section when in the presence of students or school personnel or in an area where smoking is otherwise prohibited by law.

(c) The policy adopted by a local community college board of trustees may include the following elements:

(1) Adequate notice of the policy to students, parents, the public, and school personnel.

(2) Posting of signs prohibiting at all times the use of tobacco products by any person in and on community college property.

(3) Requirements that community college personnel enforce the policy.

(4) Permission for tobacco products to be included in instructional or research activities in community college buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.

(e) Nothing in this section, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local community college board of trustees from adopting and enforcing a more restrictive policy on the use of tobacco in community college buildings, in community college facilities, on community college campuses, or at community college-related or community college-sponsored events, and in or on other community college property."

SECTION 2. The North Carolina Tobacco Prevention and Control Branch and the Health and Wellness Trust Fund Commission shall work with local community college boards of trustees to provide assistance with the development and implementation of the policy including providing information regarding smoking cessation and prevention resources.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1669*
PROPOSED COMMITTEE SUBSTITUTE S1669-CSSQ-78 [v.1]

6/10/2008 2:03:57 PM

Short Title: Community Colleges/Tobacco Free. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF AND PROVIDE GUIDANCE TO LOCAL COMMUNITY COLLEGE BOARDS OF TRUSTEES IN ADOPTING WRITTEN POLICIES PROHIBITING THE USE OF TOBACCO PRODUCTS IN BUILDINGS, ON COMMUNITY COLLEGE CAMPUSES, AT COMMUNITY COLLEGE SPONSORED EVENTS, AND IN OR ON OTHER COMMUNITY COLLEGE PROPERTY, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; and

(4) Any place on a public transportation vehicle owned or leased by local government and used by the public.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).

(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 2. Article 2 of Chapter 115D of the General Statutes is amended by adding the following new section to read:

"**§ 115D-20.1. Policy prohibiting tobacco use in community college buildings, grounds, and at community college-sponsored events.**

(a) As used in this section:

(1) "Tobacco product" includes cigarettes, cigars, blunts, bidis, pipes, chewing tobacco, snus, snuff, and any other items containing or reasonably resembling tobacco or tobacco products.

(2) "Tobacco use" includes smoking, chewing, dipping, or any other use of tobacco products.

(b) Local community college boards of trustees may adopt, implement, and enforce a written policy prohibiting at all times the use of any tobacco product by any person in community college buildings, in community college facilities, on community college campuses, in vehicles owned, leased, or operated by the local community college, and in or on any other community college property owned, leased, or operated by the local community college. The policy may also prohibit the use of all tobacco products by persons attending a community college-sponsored event.

(c) The policy adopted by a local community college board of trustees may include the following elements:

(1) Adequate notice of the policy to students, parents, the public, and school personnel.

(2) Posting of signs prohibiting at all times the use of tobacco products by any person in and on community college property.

(3) Requirements that community college personnel develop plans for successful implementation of and compliance with the policy.

(4) Permission for tobacco products to be included in instructional or research activities in community college buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.

(d) Nothing in G.S. 130A-498, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local community college board of trustees from adopting and enforcing a more restrictive policy on the use of tobacco in community college buildings, in community college facilities, on community college campuses, or at

community college-related or community college-sponsored events, and in or on other community college property."

SECTION 3. The North Carolina Tobacco Prevention and Control Branch and the Health and Wellness Trust Fund Commission shall work with local community college boards of trustees to provide assistance with the development and implementation of the policy including providing information regarding smoking cessation and prevention resources.

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

SENATE BILL 1669:
Community Colleges/Tobacco Free

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 10, 2008
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S1669-CSSQ-78		Legislative Analyst

SUMMARY: Senate Bill 1669 authorizes local community college board of trustees to adopt policies regulating tobacco use in community college settings, provides elements to consider when adopting such policies, and directs the North Carolina Tobacco Prevention and Control Branch and the Health and Wellness Trust Commission to provide assistance in developing a policy as recommended by the Justus-Warren Heart Disease and Stroke Prevention Task Force.

This act is effective when it becomes law.

CURRENT LAW:

Chapter 143, 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]. An itemized list of facilities specifically exempted from regulation by the provisions of Article 64 is set forth in G.S. 143-599. Session Law 2006-133 (HB 448) expanded the coverage of the exemption to include community colleges. In 2007, House Bill 24 created Part 2 of Article 23 in Chapter 130A which authorizes local governments to adopt local ordinances, laws or rules restricting smoking in (1) buildings owned or leased by local government or leased as lessee and occupied by local government; (2) buildings and grounds of local health departments and departments of social services; and (3) places on a public transportation vehicle owned or leased by local government and used by the public. The limitations of the term "only" in G.S. 130A-498 (b) can be interpreted to contradict the statutory exemption of regulating smoking for community colleges provided in G.S. 143-599.

BILL ANALYSIS:

Section 1 provides for the purposes of Part 2 (Local Government Regulation of Smoking) in Article 23 of Chapter 130A, "local government" does not include community colleges.

Section 2 defines tobacco product and tobacco use as used in the section and provides that local community college board of trustees may adopt written policies prohibiting tobacco use in community college buildings and facilities; on campus; in vehicles owned, leased, or operated by the community college; in other property owned, leased or operated by the community college; and at community college sponsored events. The bill provides elements of adequate notice and posting of signage as well as certain exceptions which can be included in a policy adopted by a local community college board of trustees.

Section 3 directs the North Carolina Tobacco Control Branch and Health and Wellness Trust Fund Commission to work with community college boards of trustees to provide assistance with developing policies regulating tobacco use.

EFFECTIVE DATE:

The act is effective when it becomes law.

S1669e1-SMSQ-CSSQ-78

[1] G.S. 143-595.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1669*
PROPOSED COMMITTEE SUBSTITUTE S1669-PCS15298-SQ-78

Short Title: Community Colleges/Tobacco Free. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE AUTHORITY OF AND PROVIDE GUIDANCE TO LOCAL COMMUNITY COLLEGE BOARDS OF TRUSTEES IN ADOPTING WRITTEN POLICIES PROHIBITING THE USE OF TOBACCO PRODUCTS IN BUILDINGS, ON COMMUNITY COLLEGE CAMPUSES, AT COMMUNITY COLLEGE-SPONSORED EVENTS, AND IN OR ON OTHER COMMUNITY COLLEGE PROPERTY, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; and

(4) Any place on a public transportation vehicle owned or leased by local government and used by the public.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).

(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 2. Article 2 of Chapter 115D of the General Statutes is amended by adding the following new section to read:

"**§ 115D-20.1. Policy prohibiting tobacco use in community college buildings, grounds, and at community college-sponsored events.**

(a) As used in this section:

(1) "Tobacco product" includes cigarettes, cigars, blunts, bidis, pipes, chewing tobacco, snus, snuff, and any other items containing or reasonably resembling tobacco or tobacco products.

(2) "Tobacco use" includes smoking, chewing, dipping, or any other use of tobacco products.

(b) Local community college boards of trustees may adopt, implement, and enforce a written policy prohibiting at all times the use of any tobacco product by any person in community college buildings, in community college facilities, on community college campuses, in vehicles owned, leased, or operated by the local community college, and in or on any other community college property owned, leased, or operated by the local community college. The policy may also prohibit the use of all tobacco products by persons attending a community college-sponsored event.

(c) The policy adopted by a local community college board of trustees may include the following elements:

(1) Adequate notice of the policy to students, parents, the public, and school personnel.

(2) Posting of signs prohibiting at all times the use of tobacco products by any person in and on community college property.

(3) Requirements that community college personnel develop plans for successful implementation of and compliance with the policy.

(4) Permission for tobacco products to be included in instructional or research activities in community college buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.

(d) Nothing in G.S. 130A-498, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local community college board of trustees from adopting and enforcing a more restrictive policy on the use of tobacco in community college buildings, in community college facilities, on community college campuses, or at

community college-related or community college-sponsored events, and in or on other community college property."

SECTION 3. The North Carolina Tobacco Prevention and Control Branch and the Health and Wellness Trust Fund Commission shall work with local community college boards of trustees to provide assistance with the development and implementation of the policy including providing information regarding smoking cessation and prevention resources.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1681*

Short Title:	Smoke-Free Motor Fleet.	(Public)
Sponsors:	Senators Purcell, Dorsett, Forrester; and Snow.	
Referred to:	Health Care.	

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE AUTOMOBILES IN THE STATE MOTOR FLEET TO BE SMOKE-FREE; AND TO AUTHORIZE LOCAL GOVERNMENTS TO REQUIRE LOCAL GOVERNMENT-OWNED VEHICLES TO BE SMOKE-FREE, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-491 reads as rewritten:

"**§ 130A-491. Legislative intent.**

It is the intent of the General Assembly to protect the health of individuals working in or visiting State government buildings from the risks related to secondhand smoke. It is further the intent of the General Assembly to protect the health of individuals driving or riding in State-owned passenger-carrying vehicles assigned temporarily or permanently by the Department of Administration, Motor Pool Division, to State employees or State agencies or institutions for official State business."

SECTION 2. G.S. 130A-492 reads as rewritten:

"**§ 130A-492. Definitions.**

The following definitions apply in this Article:

(1) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(2) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(3) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(4) "Vehicle". – A passenger-carrying vehicle owned by the State and assigned by the Department of Administration, Motor Pool Division, permanently or temporarily to a State employee or State agency or institution for official State business."

SECTION 3. G.S. 130A-493 reads as rewritten:

"§ 130A-493. Smoking in State government buildings and State-owned passenger-carrying vehicles prohibited.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings as provided in this section. As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:

(1) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(2) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State-owned passenger-carrying vehicles assigned permanently or temporarily by the Department of Administration, Motor Pool Division, to State employees or State agencies or institutions for official State business. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

SECTION 4. G.S. 130A-498 reads as rewritten:

"§ 130A-498. Local governments may restrict smoking in public places.

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) **(Repealed effective August 1, 2008)** Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle;~~ and~~

(4) Any place on a public transportation vehicle owned or leased by local government and used by the ~~public.~~public; and

(5) Any place on a passenger-carrying vehicle owned by local government and assigned temporarily or permanently by local government to local government employees, agencies, institutions, or facilities for official local government business.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.

(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1681*
PROPOSED COMMITTEE SUBSTITUTE S1681-CSSQ-79 [v.1]

6/10/2008 3:30:56 PM

Short Title: Smoke-Free Motor Fleet. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE AUTOMOBILES IN THE STATE MOTOR FLEET TO BE SMOKE-FREE; AND TO AUTHORIZE LOCAL GOVERNMENTS TO REQUIRE LOCAL GOVERNMENT-CONTROLLED VEHICLES TO BE SMOKE-FREE, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-491 reads as rewritten:

"**§ 130A-491. Legislative intent.**

It is the intent of the General Assembly to protect the health of individuals working in or visiting State government buildings from the risks related to secondhand smoke. It is further the intent of the General Assembly to protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned temporarily or permanently by the Department of Administration, Motor Pool Division, to State employees or State agencies or institutions for official State business."

SECTION 2. G.S. 130A-492 reads as rewritten:

"**§ 130A-492. Definitions.**

The following definitions apply in this Article:

(1a) "Local vehicle". – A passenger-carrying vehicle owned, leased or otherwise controlled by local government and assigned temporarily or permanently by local government to local government employees, agencies, institutions, or facilities for official local government business.

(1) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(2) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(3) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(4) "State vehicle". – A passenger-carrying vehicle owned, leased or otherwise controlled by the State and assigned by the Department of Administration, Motor Pool Division, permanently or temporarily to a State employee or State agency or institution for official State business."

SECTION 3. G.S. 130A-493 reads as rewritten:

"**§ 130A-493. Smoking in State government buildings and State vehicles prohibited.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings as provided in this section. As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:

(1) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(2) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

SECTION 4. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) **(Repealed effective August 1, 2008)** Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; ~~and~~

(4) Any place on a public transportation vehicle owned or leased by local government and used by the ~~public.~~public; and

(5) Any place in a local vehicle.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.

(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 5. This act becomes effective January 1, 2009.

SENATE BILL 1681: Smoke-Free Motor Fleet

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 10, 2008
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin
Version:	PCS to First Edition S1681-CSSQ-79		Committee Counsel

SUMMARY: ***Senate Bill 1681 would amend Article 23 of Chapter 130A of the General Statutes to prohibit smoking inside State-controlled passenger-carrying vehicles assigned by the Motor Pool Division to State employees or agencies or institutions for official State business. The bill would also allow local governments to restrict smoking in passenger-carrying vehicles controlled by local government and assigned to local government employees or entities for official local government business. The Proposed Committee Substitute defines State and Local vehicles to include any that are owned, leased or otherwise controlled by the State or local government and revises the bill's effective date to be January 1, 2009, to coincide with the termination of current State vehicle leasing agreements.***

CURRENT LAW: Article 23 of Chapter 130A prohibits smoking in State government buildings and allows local governments to restrict smoking in certain buildings and transportation vehicles by adopting an ordinance, law or rule. This Article applies to the areas of buildings owned, occupied or leased by State and local government.

Part 1 of Article 23 prohibits smoking in State government buildings. Smoking is permitted in such buildings to the extent the use is integral to scientific or medical research. The individual in charge of the building or the individual's designee is required to conspicuously post signs indicating that smoking is prohibited. "Smoking" is the use or possession of a lighted tobacco product. "State government building" is a building or the area of a building owned, leased or occupied by any agencies of the executive, judicial and legislative branch of government.

Part 2 of Article 23 authorizes local governments to adopt local ordinances, laws or rules restricting smoking in (1) buildings owned or leased by local government or leased as lessee and occupied by local government; (2) buildings and grounds of local health departments and departments of social services; and (3) places on a public transportation vehicle owned or leased by local government and used by the public.

"Local government" is defined as any local political subdivision of the State, any airport authority, and any authority or body created by such entity.

BILL ANALYSIS: Senate Bill 1681 would amend Article 23 of Chapter 130A of the General Statutes to prohibit smoking inside State-controlled (owned, leased or otherwise controlled) passenger-carrying vehicles assigned by the Motor Pool Division to State employees or agencies or institutions for official State business. The bill would also allow local governments to restrict smoking in passenger-carrying vehicles controlled by local governments and assigned to local government employees, agencies, institutions, or facilities for official local government business.

EFFECTIVE DATE: This act becomes effective January 1, 2009.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1681*

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

S1681-AST-64 [v.3]

Date June 11, ,2008

Comm. Sub. [YES]
Amends Title [NO]
First Edition

Senator Purcell

moves to amend the bill on page 1, line 16 through page 2, line 7 by rewriting those lines to read:

"**SECTION 2.** G. S. 130A-492 reads as rewritten:
"**§ 130A-492. Definitions.**
The following definitions apply in this Article:

(5) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned temporarily or permanently by local government to local government employees, agencies, institutions, or facilities for official local government business.

~~(1)~~(8) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

~~(2)~~(9) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

~~(3)~~(10) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(11) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned temporarily or

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1681*

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

S1681-AST-64 [v.3]

permanently by local government to State employees or State agencies, institutions, or facilities for official State business."."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1681*
PROPOSED COMMITTEE SUBSTITUTE S1681-PCS85473-SQ-79

Short Title: Smoke-Free Motor Fleet. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE AUTOMOBILES IN THE STATE MOTOR FLEET TO BE SMOKE-FREE; AND TO AUTHORIZE LOCAL GOVERNMENTS TO REQUIRE LOCAL GOVERNMENT-CONTROLLED VEHICLES TO BE SMOKE-FREE, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-491 reads as rewritten:

"**§ 130A-491. Legislative intent.**

It is the intent of the General Assembly to protect the health of individuals working in or visiting State government buildings from the risks related to secondhand smoke. It is further the intent of the General Assembly to protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned temporarily or permanently by the Department of Administration, Motor Pool Division, to State employees or State agencies or institutions for official State business."

SECTION 2. G.S. 130A-492 reads as rewritten:

"**§ 130A-492. Definitions.**

The following definitions apply in this Article:

(5) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned temporarily or permanently by local government to local government employees, agencies, institutions, or facilities for official local government business.

~~(1)~~(8) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

~~(2)~~(9) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

~~(3)~~(10)"State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(11) "State vehicle". – A passenger-carrying vehicle owned, leased or otherwise controlled by the State and assigned by the Department of Administration, Motor Pool Division, permanently or temporarily to a State employee or State agency or institution for official State business."

SECTION 3. G.S. 130A-493 reads as rewritten:

"**§ 130A-493. Smoking in State government buildings and State vehicles prohibited.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings as provided in this section. As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:

(1) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(2) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

SECTION 4. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;
(2) Building and grounds wherein local health departments and departments of social services are housed;
(3) Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; ~~and~~
(4) Any place on a public transportation vehicle owned or leased by local government and used by the ~~public.~~public; and
(5) Any place in a local vehicle.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.

(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 5. This act becomes effective January 1, 2009.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 2

SENATE BILL 1686*
Corrected Copy 5/21/08

Short Title:	Smoke-Free State and Local Bldg. Grounds.	(Public)
Sponsors:	Senators Purcell, Dorsett, Forrester; Dannelly, McKissick, and Snow.	
Referred to:	Health Care.	

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT THE GROUNDS WITHIN A CERTAIN DISTANCE OF STATE-OWNED OR OPERATED BUILDINGS BE SMOKE-FREE; AND TO AUTHORIZE LOCAL GOVERNMENTS TO DESIGNATE GROUNDS WITHIN A CERTAIN DISTANCE OF LOCALLY OWNED OR OPERATED BUILDINGS TO BE SMOKE-FREE, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-493 reads as rewritten:

"**§ 130A-493. Smoking prohibited in State government buildings and on the grounds of State government buildings.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings and on the grounds of State government buildings as provided in this section. For the purposes of this section, "grounds" means the area located within 50 linear feet of the State building. As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.

(b) Smoking is permitted inside State government buildings and on the grounds of State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the ~~building.~~ building and grounds. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:

(1) Direct any person who is smoking inside the facility or on its grounds to extinguish the lighted smoking product.

(2) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and on its grounds and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

SECTION 2. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this Section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) **(Repealed effective August 1, 2008)** Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; and

(4) Any place on a public transportation vehicle owned or leased by local government and used by the public.

(5) The grounds of buildings owned, leased as lessor, or the area leased as lessee and occupied by local government.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.

(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building owned, leased as lessor, or the area leased as lessee and occupied by local government, or wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 3. G.S. 143-601 reads as rewritten:

"**§ 143-601. Applicability of Article; local government may enact.**

(a) This Article shall not supersede nor prohibit the enactment or enforcement of any otherwise valid local law, rule, or ordinance enacted prior to October 15, 1993, regulating the use of tobacco products. However, no local law, rule, or ordinance

enacted and placed in operation prior to October 15, 1993, shall be amended to impose a more stringent standard than in effect on the date of ratification of this Article.

(b) Any local ordinance, law, or rule that regulates smoking adopted on or after October 15, 1993, shall not contain restrictions regulating smoking which exceed those established in this Article. Any such local ordinance, law, or rule may restrict smoking in accordance with this subsection and pursuant to G.S. 143-597 only in the following facilities that are not owned, leased, or occupied by local government:

(1) Repealed by Session Laws 2007-193, s. 3, effective January 1, 2008.

(2) A public meeting.

(3) The indoor space in an auditorium, arena, or coliseum, or an appurtenant building thereof.

(4) A library or museum open to the ~~public.~~public and the grounds of the library or museum. For purposes of this subdivision, "grounds" means the area located within 50 linear feet of the library or museum building.

(5) Repealed by Session Laws 2007-193, s. 3, effective January 1, 2008.

If any of the facilities or grounds listed in this subsection are owned, leased as lessor, or the area leased as lessee and occupied by local government, then the local ordinance, law, or rule restricting smoking shall be governed by Article 23 of Chapter 130A of the General Statutes."

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

SENATE BILL 1686:
Smoke-Free State and Local Bldg. Grounds

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 10, 2008
Introduced by:	Sen. Purcell	**Summary by:**	Ben Popkin
Version:	PCS to Second Edition S1686-CSSQ-80		Committee Counsel

SUMMARY: Senate Bill 1686 would expand the prohibition against smoking in State government buildings to include the grounds around those buildings. The bill would also expand existing local government authority to restrict smoking in public places to include the grounds around local government buildings and the grounds around libraries and museums.

CURRENT LAW: Article 23 of Chapter 130A prohibits smoking in State government buildings and allows local governments to restrict smoking in certain buildings and transportation vehicles by adopting an ordinance, law or rule. This Article applies to the areas of buildings owned, occupied or leased by State and local government.

Part 1 of Article 23 prohibits smoking in State government buildings. Smoking is permitted in such buildings to the extent the use is integral to scientific or medical research. The individual in charge of the building or the individual's designee is required to conspicuously post signs indicating that smoking is prohibited. "Smoking" is the use or possession of a lighted tobacco product. "State government building" is a building or the area of a building owned, leased or occupied by any agencies of the executive, judicial and legislative branch of government.

Part 2 of Article 23 authorizes local governments to adopt local ordinances, laws or rules restricting smoking in (1) buildings owned or leased by local government or leased as lessee and occupied by local government; (2) buildings and grounds of local health departments and departments of social services; and (3) places on a public transportation vehicle owned or leased by local government and used by the public.

"Local government" is defined as any local political subdivision of the State, any airport authority, and any authority or body created by such entity.

Article 64 of Chapter 143 sets forth the following provisions regarding smoking in public places: Identification of areas in State-controlled buildings that may be designated as nonsmoking[1]; Identification of facilities that are exempt from Article 64 (allowing these facilities to make any policy regarding smoking, including banning smoking outright or allowing it as they choose)[2]; Limitation on types of restrictions local government may place on smoking[3].

BILL ANALYSIS: Sections 1 and 2 of Senate Bill 1686 would amend Article 23 of Chapter 130A to expand the prohibition against smoking in State government buildings to include the grounds around those buildings and to expand the authority of local governments to adopt ordinance, law or rule to restrict smoking on the grounds of buildings owned, leased or occupied by local government. For the purposes of these sections, grounds includes the area controlled by either State or local government that is located within 50 linear feet of the State or local government building. Section 3 would amend Article 64 of Chapter 143 to add grounds of libraries or museums to the buildings themselves, which may already have smoking restrictions placed on them by local action.

EFFECTIVE DATE: This act is effective when it becomes law. *S1686e2-SMRD-CSSQ-80*

[1] G.S. 143-597. Nonsmoking areas in State-controlled buildings.
[2] G.S. 143-599. Exemptions.
[3] G.S. 143-601. Applicability of Article; local government may enact.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1686*
Corrected Copy 5/21/08
PROPOSED COMMITTEE SUBSTITUTE S1686-CSSQ-80 [v.1]

6/10/2008 3:36:24 PM

Short Title: Smoke-Free State and Local Bldg. Grounds. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT THE GROUNDS WITHIN A CERTAIN DISTANCE OF STATE-OWNED OR OPERATED BUILDINGS BE SMOKE-FREE; AND TO AUTHORIZE LOCAL GOVERNMENTS TO DESIGNATE GROUNDS WITHIN A CERTAIN DISTANCE OF LOCALLY OWNED OR OPERATED BUILDINGS TO BE SMOKE-FREE, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-493 reads as rewritten:

"**§ 130A-493. Smoking prohibited in State government buildings and on the grounds of State government buildings.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings and on the grounds of State government buildings as provided in this section. For the purposes of this section, "grounds" means the area controlled by State government that is located within 50 linear feet of the State government building. As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.

(b) Smoking is permitted inside State government buildings and on the grounds of State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the ~~building.~~ building and grounds. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, in any State psychiatric

hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:

(1) Direct any person who is smoking inside the facility or on its grounds to extinguish the lighted smoking product.

(2) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and on its grounds and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

SECTION 2. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this Section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) **(Repealed effective August 1, 2008)** Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; and

(4) Any place on a public transportation vehicle owned or leased by local government and used by the public.

(5) The grounds of buildings owned, leased as lessor, or the area leased as lessee and occupied by local government.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.

(d) As used in this Part, "grounds" means the area controlled by local government that is located within 50 linear feet of a building owned, leased as lessor, or the area leased as lessee and occupied by local government, or wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 3. G.S. 143-601 reads as rewritten:

"**§ 143-601. Applicability of Article; local government may enact.**

(a) This Article shall not supersede nor prohibit the enactment or enforcement of any otherwise valid local law, rule, or ordinance enacted prior to October 15, 1993,

regulating the use of tobacco products. However, no local law, rule, or ordinance enacted and placed in operation prior to October 15, 1993, shall be amended to impose a more stringent standard than in effect on the date of ratification of this Article.

(b) Any local ordinance, law, or rule that regulates smoking adopted on or after October 15, 1993, shall not contain restrictions regulating smoking which exceed those established in this Article. Any such local ordinance, law, or rule may restrict smoking in accordance with this subsection and pursuant to G.S. 143-597 only in the following facilities that are not owned, leased, or occupied by local government:

(1) Repealed by Session Laws 2007-193, s. 3, effective January 1, 2008.

(2) A public meeting.

(3) The indoor space in an auditorium, arena, or coliseum, or an appurtenant building thereof.

(4) A library or museum open to the ~~public.~~public and the grounds of the library or museum. For purposes of this subdivision, "grounds" means the area controlled by the library or museum that is located within 50 linear feet of the library or museum building.

(5) Repealed by Session Laws 2007-193, s. 3, effective January 1, 2008.

If any of the facilities or grounds listed in this subsection are owned, leased as lessor, or the area leased as lessee and occupied by local government, then the local ordinance, law, or rule restricting smoking shall be governed by Article 23 of Chapter 130A of the General Statutes."

SECTION 4. 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 6/11/08

S. B. No. 1686 Amendment No. _____ (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

Rep.)
Sen.) Nesbitt

moves to amend the bill on page 1, line 15

( ) WHICH CHANGES THE TITLE

by rewriting the line to read:

"purposes of this section, "grounds" means the area owned, leased as lessor, or leased as lessee by State government that";

and on page 2, line 35, by deleting the word "controlled" and substituting the phrase "owned, leased as lessor, or leased as lessee"; and on page 3, line 15 by ~~rewriting the~~ deleting the word "controlled" and substituting the phrase "owned, leased as lessor, or leased as lessee".

SIGNED Martin Nesbitt

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1686*
Corrected Copy 5/21/08
PROPOSED COMMITTEE SUBSTITUTE S1686-PCS75583-SQ-80

Short Title: Smoke-Free State and Local Bldg. Grounds. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT THE GROUNDS WITHIN A CERTAIN DISTANCE OF STATE-OWNED OR OPERATED BUILDINGS BE SMOKE-FREE; AND TO AUTHORIZE LOCAL GOVERNMENTS TO DESIGNATE GROUNDS WITHIN A CERTAIN DISTANCE OF LOCALLY OWNED OR OPERATED BUILDINGS TO BE SMOKE-FREE, AS RECOMMENDED BY THE JUSTUS-WARREN HEART DISEASE AND STROKE PREVENTION TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-493 reads as rewritten:

"**§ 130A-493. Smoking prohibited in State government buildings and on the grounds of State government buildings.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings and on the grounds of State government buildings as provided in this section. For the purposes of this section, "grounds" means the area owned, leased as lessor, or leased as lessee by State government that is located within 50 linear feet of the State government building. As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.

(b) Smoking is permitted inside State government buildings and on the grounds of State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the ~~building.~~ building and grounds. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette.

enclosed in a red circle with a red bar across it. In addition, in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:

(1) Direct any person who is smoking inside the facility or on its grounds to extinguish the lighted smoking product.

(2) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and on its grounds and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

SECTION 2. G.S. 130A-498 reads as rewritten:

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) Notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this Section.

(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:

(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;

(2) Building and grounds wherein local health departments and departments of social services are housed;

(3) Public schools, school facilities, on school campuses, at school-related or school-sponsored events, in or on other school property, public school buses, or at day care centers. Such restrictions may be imposed by local school boards having ownership or jurisdiction over the building, campus, event, property, or vehicle; ~~and~~

(4) Any place on a public transportation vehicle owned or leased by local government and used by the ~~public.~~public; and

(5) The grounds of buildings owned, leased as lessor, or the area leased as lessee and occupied by local government.

(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.

(d) As used in this Part, "grounds" means the area owned, leased as lessor, or leased as lessee by local government that is located within 50 linear feet of a building owned, leased as lessor, or the area leased as lessee and occupied by local government, or wherein a local health department or a local department of social services is housed.

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122."

SECTION 3. G.S. 143-601 reads as rewritten:

"**§ 143-601. Applicability of Article; local government may enact.**

(a) This Article shall not supersede nor prohibit the enactment or enforcement of any otherwise valid local law, rule, or ordinance enacted prior to October 15, 1993,

regulating the use of tobacco products. However, no local law, rule, or ordinance enacted and placed in operation prior to October 15, 1993, shall be amended to impose a more stringent standard than in effect on the date of ratification of this Article.

(b) Any local ordinance, law, or rule that regulates smoking adopted on or after October 15, 1993, shall not contain restrictions regulating smoking which exceed those established in this Article. Any such local ordinance, law, or rule may restrict smoking in accordance with this subsection and pursuant to G.S. 143-597 only in the following facilities that are not owned, leased, or occupied by local government:

(1) Repealed by Session Laws 2007-193, s. 3, effective January 1, 2008.

(2) A public meeting.

(3) The indoor space in an auditorium, arena, or coliseum, or an appurtenant building thereof.

(4) A library or museum open to the ~~public.~~public and the grounds of the library or museum. For purposes of this subdivision, "grounds" means the area owned, leased as lessor, or leased as lessee by the library or museum that is located within 50 linear feet of the library or museum building.

(5) Repealed by Session Laws 2007-193, s. 3, effective January 1, 2008.

If any of the facilities or grounds listed in this subsection are owned, leased as lessor, or the area leased as lessee and occupied by local government, then the local ordinance, law, or rule restricting smoking shall be governed by Article 23 of Chapter 130A of the General Statutes."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007

S 1

SENATE BILL 1687*

Short Title:	Establish Public Health Incubator Program.	(Public)
Sponsors:	Senators Purcell; Atwater, Berger of Franklin, Dannelly, McKissick, Queen, Snow, and Weinstein.	
Referred to:	Health Care.	

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA PUBLIC HEALTH INCUBATOR PROGRAM WITHIN THE NORTH CAROLINA INSTITUTE FOR PUBLIC HEALTH, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. There is established within the North Carolina Institute for Public Health, the North Carolina Public Health Incubator Program (Program). The primary mission of the Program shall be to support voluntary local health department collaborative efforts, in partnership with the Department of Health and Human Services, Division of Public Health, to address the State's regional health needs. Additionally, the Program shall make every effort to address urgent public health needs as identified in the North Carolina Public Health Improvement Plan – Public Health Task Force 2008 Final Report.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1687*
PROPOSED COMMITTEE SUBSTITUTE S1687-CSSQ-74 [v.4]

6/10/2008 4:28:08 PM

Short Title: Public Health Incubator Prgm Annual Report. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA PUBLIC HEALTH INCUBATOR PROGRAM TO REPORT ANNUALLY TO THE PUBLIC HEALTH STUDY COMMISSION, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Public Health Incubator Program, initially authorized in Section 10.32 of S.L. 2004-124, within the North Carolina Institute for Public Health shall report by October 1, 2008, and annually thereafter to the Public Health Study Commission on the following:

(1) The status of its primary mission to support voluntary local health department collaborative efforts, in partnership with the Department of Health and Human Services, Division of Public Health, to address the State's regional health needs.

(2) Its efforts to address urgent public health needs as identified in the 2008 final report of the Public Health Task Force's Public Health Improvement Plan.

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

SENATE BILL 1687:
Public Health Incubator Program

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 10, 2008
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker
Version:	PCS to First Edition S1687-CSSQ-74		Legislative Analyst

SUMMARY: Senate Bill 1687 directs the North Carolina Public Health Incubator Program established within the North Carolina Institute for Public Health to report by October 1, 2008 and annually thereafter to the Public Health Study Commission on the following:

- ***The status of its primary mission to support voluntary local health department collaborative efforts, in partnership with the Department of Health and Human Services, Division of Public Health, to address the State's regional health needs.***
- ***Its efforts to address urgent public health needs as identified in the 2008 final report of the Public Health Task Force's Public Health Improvement Plan.***

This act is effective when it becomes law.

CURRENT LAW:

Section 10.32(a) of Session Law 2004-124 appropriated funds to the Department of Health and Human Services for 2004-2005 fiscal year. The funds were allocated to the North Carolina Institute for Public Health, School of Public Health at the University of North Carolina at Chapel Hill to coordinate the development of "public health incubators." Funds have been appropriated to continue the public health incubator program each year since 2004.

BACKGROUND: This was a recommendation of the Public Health Study Commission.

S1687e1-SMSQ-CSSQ-74

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S D

SENATE BILL 1687*
PROPOSED COMMITTEE SUBSTITUTE S1687-PCS55738-SQ-74

Short Title: Public Health Incubator Prgm Annual Report. (Public)

Sponsors:

Referred to:

May 20, 2008

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA PUBLIC HEALTH INCUBATOR PROGRAM TO REPORT ANNUALLY TO THE PUBLIC HEALTH STUDY COMMISSION, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Public Health Incubator Program, initially authorized in Section 10.32 of S.L. 2004-124, within the North Carolina Institute for Public Health shall report by October 1, 2008, and annually thereafter to the Public Health Study Commission on the following:

(1) The status of its primary mission to support voluntary local health department collaborative efforts, in partnership with the Department of Health and Human Services, Division of Public Health, to address the State's regional health needs.

(2) Its efforts to address urgent public health needs as identified in the 2008 final report of the Public Health Task Force's Public Health Improvement Plan.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 3

HOUSE BILL 964

Committee Substitute Favorable 5/10/07

Committee Substitute #2 Favorable 7/24/07

Short Title: Expand Definition of Home Care Services. (Public)

Sponsors:

Referred to:

March 22, 2007

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE DEFINITION OF HOME CARE SERVICES TO INCLUDE IN-HOME COMPANION, SITTER, AND RESPITE CARE SERVICES PROVIDED TO AN INDIVIDUAL.

The General Assembly of North Carolina enacts:

SECTION 1. 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 licensed agency site.

(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;~~ 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;~~home.

c. Medical social ~~services;~~services.

d. In-home aide services that involve hands-on care to an ~~individual;~~ individual.
e. Infusion nursing ~~services; and~~services.
f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.
g. In-home companion, sitter, and respite care services provided to an individual.
h. Homemaker services provided in combination with in-home companion, sitter, respite, or other home care services.

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. The term sitter does not include child care facilities licensed in accordance with Chapter 110 of the General Statutes. The term respite care does not include facilities or services licensed in accordance with Chapter 122C of the General Statutes. The terms in-home companion, sitter, homemaker, and respite care services do not include (i) services certified or otherwise overseen by the Department as not providing personal care or (ii) services administered on a voluntary basis for which there is not reimbursement from the recipient or anyone acting on the recipient's behalf.

(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 2. The North Carolina Medical Care Commission shall adopt rules to implement Section 1 of this act.

SECTION 3. Section 1 of this act becomes effective January 1, 2009. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H D

HOUSE BILL 964

Committee Substitute Favorable 5/10/07
Committee Substitute #2 Favorable 7/24/07
PROPOSED SENATE COMMITTEE SUBSTITUTE H964-CSSHf-57 [v.2]

6/10/2008 2:27:59 PM

Short Title: Expand Definition of Home Care Services. (Public)

Sponsors:

Referred to:

March 22, 2007

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE DEFINITION OF HOME CARE SERVICES TO INCLUDE IN-HOME COMPANION, SITTER, AND RESPITE CARE SERVICES PROVIDED TO AN INDIVIDUAL AND TO INCREASE THE ANNUAL LICENSE FEE FOR HOME CARE AGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. 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 licensed agency site.

(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;~~ 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;~~home.

c. Medical social ~~services;~~services.

d. In-home aide services that involve hands-on care to an ~~individual;~~ individual.

e. Infusion nursing ~~services; and~~services.

f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.

g. In-home companion, sitter, and respite care services provided to an individual.

h. Homemaker services provided in combination with in-home companion, sitter, respite, or other home care services.

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. The term sitter does not include child care facilities licensed in accordance with Chapter 110 of the General Statutes. The term respite care does not include facilities or services licensed in accordance with Chapter 122C of the General Statutes. The terms in-home companion, sitter, homemaker, and respite care services do not include (i) services certified or otherwise overseen by the Department as not providing personal care or (ii) services administered on a voluntary basis for which there is not

reimbursement from the recipient or anyone acting on the recipient's behalf.

(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 2. G.S. 131E-138 reads as rewritten:

"**§ 131E-138. Licensure requirements.**

(a) No person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

(b) Repealed by Session Laws 1991, c. 59, s. 1.

(c) An application for a license shall be available from the Department, and each application filed with the Department shall contain all information requested by the Department. A license shall be granted to the applicant upon a determination by the Department that the applicant has complied with the provisions of this Part and the rules promulgated by the Commission under this Part. The Department shall charge the applicant a nonrefundable annual license fee in the amount of ~~three hundred fifty dollars ($350.00).~~ four hundred dollars ($400.00).

(d) The Department shall renew the license in accordance with the rules of the Commission.

(e) Each license shall be issued only for the premises and persons named in the license and shall not be transferable or assignable except with the written approval of the Department.

(f) The license shall be posted in a conspicuous place on the licensed premises.

(g) The Commission shall adopt rules to ensure that a home care agency shall be deemed to meet the licensure requirements and issued a license without further review or inspection if: (i) the agency is already certified or accredited by the Joint Commission on Accreditation of Health Care Organizations, National League for Nursing, National Home Caring Council, North Carolina Accreditation Commission for In-Home Aide Services, or other entities recognized by the Commission and (ii) the agency is certified or accredited for all of the home care services that it provides; or (iii) in the case of continuing care retirement communities licensed by the North Carolina Department of Insurance under Article 64 of Chapter 58 which also have nursing beds licensed by the Department of Health and Human Services under Article 6 of Chapter 131E, the Department certifies, as part of its licensure review or survey of the nursing beds, that the facility also meets all of the rules and regulations adopted by the Commission pursuant to this Part. The Department may, at its discretion, determine the frequency and extent of the review and inspection of home health agencies already certified as meeting federal requirements, but not more frequently than on an annual basis for routine reviews."

SECTION 3. The North Carolina Medical Care Commission shall adopt rules to implement Section 1 of this act.

SECTION 4. Section 1 of this act becomes effective January 1, 2010. Section 2 of this act becomes effective July 1, 2009. The remainder of this act is effective when it becomes law.

HOUSE BILL 964:
Expand Definition of Home Care Services

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	June 10, 2008
Introduced by:	Reps. Clary, Farmer-Butterfield, Earle	**Summary by:**	Shawn Parker
Version:	PCS to Third Edition H964-CSSHf-57		Legislative Analyst

SUMMARY: HB 964 increases the annual license fee for home care agencies from $350 to $400 and expands the definition of home care services to include the following services:

- ***In-home companion, sitter, and respite care services provided to an individual.***
- ***Homemaker services provided in combination with in-home companion, sitter, respite, or other home care services.***

"Sitter" does not include child care facilities licensed under Chapter 110 (Child Welfare).

"Respite care" does not include facilities or services licensed under Chapter 122C (Mental health, Developmental Disabilities, and Substance Abuse Act of 1985).

"In-home companion, sitter, and respite care services" are not within the definition of home care services if they are (1) certified by the Department of Health and Human Services as not providing hands-on care; (2) administered in a voluntary basis.

CURRENT LAW: No person or governmental unit shall operate a home care agency without obtaining a license from the Department and Health and Human Services.[1] There is a nonrefundable annual license fee of $350.

BILL ANALYSIS:

Section 1 adds the following services to the definition of home care services that would be subject to the licensure requirement:

- In-home companion, sitter, and respite care services provided to an individual.
- Homemaker services provided in combination with in-home companion, sitter, respite, or other home care services.

The following would be excluded from the above terms and therefore from licensure:

- Child care facilities licensed under Chapter 110. This includes daycare centers.
- Facilities or services licensed under Chapter 122C. This includes facilities for the mentally ill, developmentally disabled, and substance abusers.
- Services certified or otherwise overseen by the DHHS as not providing personal care.
- Services administered on a voluntary basis for which there is not reimbursement from the recipient or anyone acting on the recipient's behalf.

[1] Home Care Agency Licensure Act (G.S. §§ 131E-135 through 131E-142)

Section 2 increases the nonrefundable home care agency licensure applicant fee from three hundred and fifty dollars ($350) to four hundred dollars ($400).

Section 3 directs the North Carolina Medical Care Commission to adopt rules to implement these expansions to the definition of home care services.

EFFECTIVE DATE: Section 1 (expand definition of home care services) of the act becomes effective January 1, 2010, **Section 2** (fee increase) of the act becomes effective July 1, 2009, the remainder of the act is effective when the bill becomes law.

Martha Walston contributed significantly to this summary.

H0964e3-SMSQ-CSSHf-57

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 25, 2008	11:00 AM	544

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 2127	RICCs repealed.	Representative Alexander
SB 1892	Autism Committee Recommendations.	Senator Purcell

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

SENATE COMMITTEE ON HEALTH CARE
MINUTES
JUNE 25, 2008

The Senate Committee on Health Care met at 11:00 a.m. on Wednesday, June 25th in Room 544 of the Legislative Office Building, with Senator Purcell presiding.

Two bills were on the agenda (Attachment I), with House Bill 2127 AN ACT TO REPEAL THE LAW ESTABLISHING REGIONAL INTERAGENCY COORDINATING COUNCILS UNDER THE LAWS RELATING TO EARLY INTERVENTION SERVICES FOR CHILDREN FROM BIRTH TO FIVE YEARS OF AGE WITH DISABILITIES, SO AS TO SAVE FUNDS AND AVOID DUPLICATION (Attachment II), sponsored by Representative Alexander, being considered first. She was present to explain her bill. An explanation is included with these minutes as Attachment III. After discussion, a motion for a favorable report was made by Senator Dorsett. Motion carried.

The second bill considered was Senate Bill 1892 AN ACT TO AUTHORIZE A SILVER ALERT TO BE ISSUED FOR A PERSON OF ANY AGE, TO AUTHORIZE AND FUND THE PROJECTION OF AN EDUCATIONAL VIDEO, AND TO STUDY THE TRAINING NEEDS OF THE JUDICIAL SYSTEM IN RESPONDING TO PERSONS WITH AUTISM, AS RECOMMENDED BY THE JOINT STUDY COMMITTEE ON AUTISM SPECTRUM DISORDER AND PUBLIC SAFETY (Attachment IV), sponsored by Senator Purcell. Senator Bingham took over as Chair of the Committee in order that Senator Purcell might explain his bill. He presented a Committee Substitute and Senator Foriest moved that the Committee Substitute be adopted for consideration; motion carried.

Senator Purcell explained this Committee Substitute (Attachment V), and a bill explanation is attached to these minutes as Attachment VI. After discussion, a motion was made for an unfavorable report for the original bill and a favorable report for the Committee Substitute for Senate Bill 1892.

A copy of the Committee Report (Attachment VII) is attached to these minutes. Meeting adjourned.

Respectfully submitted,

Becky Hedspeth

Becky Hedspeth, Committee Clerk

William R Purcell

Senator William Purcell, Co-Chair

Attachment I

HEALTH CARE MEETING AGENDA

June 25, 2008
Rm. 544

HB 2127 **RICC's Repealed**

SB 1892 **Autism Committee Recommendations**

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

Attachment 11

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 2127

Short Title:	RICCs Repealed.	(Public)
Sponsors:	Representatives Alexander; Church and Faison.	
Referred to:	Rules, Calendar, and Operations of the House.	

May 15, 2008

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE LAW ESTABLISHING REGIONAL INTERAGENCY COORDINATING COUNCILS UNDER THE LAWS RELATING TO EARLY INTERVENTION SERVICES FOR CHILDREN FROM BIRTH TO FIVE YEARS OF AGE WITH DISABILITIES, SO AS TO SAVE FUNDS AND AVOID DUPLICATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-179.5A is repealed.

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

Attachment III

HOUSE BILL 2127: RICCs Repealed

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	June 24, 2008
Introduced by:	Rep. M. Alexander	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 2127 would repeal the statutory provision that established Regional Interagency Coordinating Councils for Children from Birth to Five with Disabilities and Their Families (Regional Councils).***

CURRENT LAW: G.S. 143B-179.5 establishes the Governor's Interagency Coordinating Council (NC-ICC). The NC-ICC advises, educates, and guides various agencies and programs providing services for children birth to five years old and their families.

18 Regional Interagency Coordinating Councils were established in G.S. 143B-179A by S.L. 2003-391. The Regional Councils correspond with the catchment areas of the Children's Developmental Services Agencies of the Division of Public Health, Department of Health and Human Services. Each of the Regional Councils is responsible for developing an early intervention plan, in collaboration with the corresponding Children's Developmental Services Agency. The early intervention plan must specifically address the efforts designated as local responsibilities in the "Individuals with Disabilities Act" (IDEA), P.L. 105-17.

G.S. 143B-179A directs the appointment of members, the selection of cochairs, vacancies, meetings, quorums, and reporting requirements for the Regional Councils.

BILL ANALYSIS: House Bill 2127 would repeal G.S. 143B-179.5A. Repealing this section of the statutes would eliminate a duplication of responsibilities that resulted from recent federal action to address early intervention and developmental services for children that the State had already addressed in earlier State legislative action (see background, below).

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: In the 2004 reauthorization of the "Individuals with Disabilities Education Act" (IDEA), P.L. 108-446, Congress assigned the duties that were already being performed in North Carolina by the Regional Councils to two lead agencies: Infant Toddler Program (Part C of IDEA - birth to age 3) and the Preschool Program (Part B of IDEA - ages 3 to 5). The changes in federal law resulted in a duplication of responsibilities at the regional level.

Susan Barham, staff to House Health, substantially contributed to this summary.

H2127e1-SMRD

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S 1

SENATE BILL 1892*

Short Title:	Autism Committee Recomendations.	(Public)
Sponsors:	Senators Purcell; Dorsett, Jenkins, Jones, Malone, and McKissick.	
Referred to:	Health Care.	

May 22, 2008

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE A SILVER ALERT TO BE ISSUED FOR A PERSON OF ANY AGE, TO AUTHORIZE AND FUND THE PRODUCTION OF AN EDUCATIONAL VIDEO, AND TO STUDY THE TRAINING NEEDS OF THE JUDICIAL SYSTEM IN RESPONDING TO PERSONS WITH AUTISM, AS RECOMMENDED BY THE JOINT STUDY COMMITTEE ON AUTISM SPECTRUM DISORDER AND PUBLIC SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-499.8(b) reads as rewritten:

"(b) If the Center receives a report that involves a missing person who is believed to be suffering from dementia or other cognitive impairment, for the protection of the missing person from potential abuse or other physical harm, neglect, or exploitation, the Center shall issue an alert providing for rapid dissemination of information statewide regarding the missing person. The Center shall make every effort to disseminate the information as quickly as possible when ~~the missing person is 18 years of age or older, and~~ the person's status as missing has been reported to a law enforcement agency."

SECTION 2. The UNC-CH Division TEACCH Autism Program (TEACCH), in consultation with the School of Government and the Autism Society of NC, shall develop a video to raise awareness of autism for those involved in government and public service, including information on recognizing the signs and symptoms of autism spectrum disorders, and contacts for further information on appropriate responses to individuals with autism.

SECTION 3. The School of Government, in consultation with the Autism Society of NC, TEACCH, and appropriate legal associations and organizations, shall study the various groups in the judicial system for which additional training may be necessary on the legal issues and appropriate responses to persons with autism. The study shall include judges, district attorneys, defense attorneys, guardians ad litem, victim witness coordinators, magistrates, juvenile court counselors, and any other group in the judicial system identified as needing additional training. The School of

Government shall develop a proposal for the most appropriate way to deliver the necessary training to each identified group and determine what funding, if any, is necessary to deliver the training. The School of Government shall report its findings to the Joint Study Committee on Autism Spectrum Disorder and Public Safety no later than October 1, 2008.

SECTION 4. The General Assembly shall appropriate funds for the 2008-2009 fiscal year to implement Section 2 of this Act.

SECTION 5. This act is effective when it becomes law.

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007

S D

SENATE BILL 1892*
PROPOSED COMMITTEE SUBSTITUTE S1892-CSSQ-84 [v.1]

6/24/2008 10:57:14 AM

Short Title: Autism Committee Recommendations. (Public)

Sponsors:

Referred to:

May 22, 2008

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE A SILVER ALERT TO BE ISSUED FOR A PERSON OF ANY AGE, TO AUTHORIZE THE PRODUCTION OF AN EDUCATIONAL VIDEO, AND TO STUDY THE TRAINING NEEDS OF THE JUDICIAL SYSTEM IN RESPONDING TO PERSONS WITH AUTISM, AS RECOMMENDED BY THE JOINT STUDY COMMITTEE ON AUTISM SPECTRUM DISORDER AND PUBLIC SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-499.8(b) reads as rewritten:

"(b) If the Center receives a report that involves a missing person who is believed to be suffering from dementia or other cognitive impairment, for the protection of the missing person from potential abuse or other physical harm, neglect, or exploitation, the Center shall issue an alert providing for rapid dissemination of information statewide regarding the missing person. The Center shall make every effort to disseminate the information as quickly as possible when ~~the missing person is 18 years of age or older, and~~ the person's status as missing has been reported to a law enforcement agency."

SECTION 2. The UNC-CH Division TEACCH Autism Program (TEACCH), in consultation with the School of Government and the Autism Society of NC, shall develop a video to raise awareness of autism for those involved in government and public service, including information on recognizing the signs and symptoms of autism spectrum disorders, and contacts for further information on appropriate responses to individuals with autism.

SECTION 3. The School of Government, in consultation with the Autism Society of NC, TEACCH, and appropriate legal associations and organizations, shall study the various groups in the judicial system for which additional training may be necessary on the legal issues and appropriate responses to persons with autism. The study shall include judges, district attorneys, defense attorneys, guardians ad litem, victim witness coordinators, magistrates, juvenile court counselors, and any other group

in the judicial system identified as needing additional training. The School of Government shall develop a proposal for the most appropriate way to deliver the necessary training to each identified group and determine what funding, if any, is necessary to deliver the training. The School of Government shall report its findings to the Joint Study Committee on Autism Spectrum Disorder and Public Safety no later than October 1, 2008.

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

Attachment VI

SENATE BILL 1892:
Autism Committee Recommendations

BILL ANALYSIS

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 24, 2008
Introduced by:	Sen. Purcell	**Summary by:**	Shawn Parker Legislative Analyst
Version:	PCS to First Edition S1892-CSSQ-84		

SUMMARY: ***Senate Bill 1892 authorizes the North Carolina Center for Missing Persons to issue a Silver Alert for missing persons of any age believed to be suffering from dementia or other cognitive impairment, directs UNC-CH Division TEACCH Autism Program to develop a video to raise awareness of autism for those involved in government and public service, and directs the School of Government to study the various groups in the judicial system and determine training needs relating to responding to persons with autism.***

The Proposed Committee Substitute removes the direction of the General Assembly to appropriate funds for developing the video.

CURRENT LAW:

Part 5A of G.S. § 143B establishes the North Carolina Center for Missing Persons ("the Center"). The purpose of this organization is to serve as a central repository for information regarding missing persons in North Carolina, with an emphasis on missing children.

§143B-499.8 establishes the "Silver Alert System" within the Center to provide a statewide alert system for rapid dissemination of information regarding missing individuals 18 years of age and older believed to be suffering from dementia or other cognitive impairment.

BILL ANALYSIS:

Section 1 amends G.S. 143B-499.8(b) by removing the requirement that the missing person is 18 years of age or older in order to issue a Silver Alert.

Section 2 directs TEACCH, in consultation with the School of Government and the Autism Society of NC to develop a video to raise awareness of autism for those in government and public service. The video should include information on recognizing signs and symptoms of autism spectrum disorder and contacts for information on appropriate responses to those individuals.

Section 3 directs the School of Government (SOG), in consultation with the Autism Society of NC, TEACCH, and other organizations, to study and determine additional training needs to ensure appropriate responses to persons with autism within the legal system. The section further directs the SOG to develop a proposal for funding and delivering the necessary training and report to the Joint Study Committee on Autism Spectrum Disorder and Public Safety by October 1, 2008.

EFFECTIVE DATE: The act is effective when it becomes law.

BACKGROUND: Between January and May 2008, North Carolina issued 17 Silver Alerts. Of those 17 alerts 15 were found unharmed.[1] This is a recommendation of the Joint Study Committee on Autism Spectrum Disorder and Public Safety.

S1892e1-SMSQ-CSSQ-84

[1] http://www.ncsl.org/programs/health/shn/2008/sn516c.htm retrieved 5/27/08

Attachment VII

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

CORRECTED REPORT #2

Wednesday, June 25, 2008

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

FAVORABLE

H.B. **2127** RICCs Repealed.

Sequential Referral:	None
Recommended Referral:	None

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

S.B. **1892** Autism Committee Recomendations.

Draft Number:	PCS55759
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, July 2, 2008 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 2, 2008, in Room 544 of the Legislative Office Building, with ten 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 Bingham stated there was one bill, House Bill 2523, ***Autism Committee Recommendation***, and that Senator Purcell had already run this same identical bill. Senator Purcell stated this very same bill passed the House and Senate within one hour of each other and that they decided to run Representative England's bill, which passed the House 113 – 0. Senator Purcell's bill passed the Senate 49-0. Senator Purcell offered to go back thought the bill again if that was the committee's wishes. Senator Hartsell made a motion for a favorable report. The bill passed.

The meeting adjourned at 11:08 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

Senate Health Care Committee
Wednesday, July 2, 2008, 11:00 AM
Room 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 2523	**Autism Committee Recomendations.**	**Representative England, M.D.** **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, July 02, 2008

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

FAVORABLE

H.B. **2523** Autism Committee Recomendations.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 2523*
Committee Substitute Favorable 6/11/08

Short Title: Autism Committee Recommendations. (Public)

Sponsors:

Referred to:

May 26, 2008

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE A SILVER ALERT TO BE ISSUED FOR A PERSON OF ANY AGE, TO AUTHORIZE THE PRODUCTION OF AN EDUCATIONAL VIDEO, AND TO STUDY THE TRAINING NEEDS OF THE JUDICIAL SYSTEM IN RESPONDING TO PERSONS WITH AUTISM, AS RECOMMENDED BY THE JOINT STUDY COMMITTEE ON AUTISM SPECTRUM DISORDER AND PUBLIC SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-499.8(b) reads as rewritten:

"(b) If the Center receives a report that involves a missing person who is believed to be suffering from dementia or other cognitive impairment, for the protection of the missing person from potential abuse or other physical harm, neglect, or exploitation, the Center shall issue an alert providing for rapid dissemination of information statewide regarding the missing person. The Center shall make every effort to disseminate the information as quickly as possible when ~~the missing person is 18 years of age or older, and~~ the person's status as missing has been reported to a law enforcement agency."

SECTION 2. The UNC-CH Division TEACCH Autism Program (TEACCH), in consultation with the School of Government and the Autism Society of NC, shall develop a video to raise awareness of autism for those involved in government and public service, including information on recognizing the signs and symptoms of autism spectrum disorders, and contacts for further information on appropriate responses to individuals with autism.

SECTION 3. The School of Government, in consultation with the Autism Society of NC, TEACCH, and appropriate legal associations and organizations, shall study the various groups in the judicial system for which additional training may be necessary on the legal issues and appropriate responses to persons with autism. The study shall include judges, district attorneys, defense attorneys, guardians ad litem, victim witness coordinators, magistrates, juvenile court counselors, and any other group in the judicial system identified as needing additional training. The School of

Government shall develop a proposal for the most appropriate way to deliver the necessary training to each identified group and determine what funding, if any, is necessary to deliver the training. The School of Government shall report its findings to the Joint Study Committee on Autism Spectrum Disorder and Public Safety no later than October 1, 2008.

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

HOUSE BILL 2523:
Autism Committee Recommendations

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 1, 2008
Introduced by:	Reps. England, M. Alexander	**Summary by:**	Shawn Parker
Version:	Second Edition		Legislative Analyst

SUMMARY: House Bill 2523 authorizes the North Carolina Center for Missing Persons to issue a Silver Alert for missing persons of any age believed to be suffering from dementia or other cognitive impairment, directs UNC-CH Division TEACCH Autism Program to develop a video to raise awareness of autism for those involved in government and public service, and directs the School of Government to study the various groups in the judicial system and determine training needs relating to responding to persons with autism.

CURRENT LAW:

Part 5A of G.S. § 143B establishes the North Carolina Center for Missing Persons ("the Center"). The purpose of this organization is to serve as a central repository for information regarding missing persons in North Carolina, with an emphasis on missing children.

§143B-499.8 establishes the "Silver Alert System" within the Center to provide a statewide alert system for rapid dissemination of information regarding missing individuals 18 years of age and older believed to be suffering from dementia or other cognitive impairment.

BILL ANALYSIS:

Section 1 amends G.S. 143B-499.8(b) by removing the requirement that the missing person is 18 years of age or older in order to issue a Silver Alert.

Section 2 directs TEACCH, in consultation with the School of Government and the Autism Society of NC to develop a video to raise awareness of autism for those in government and public service. The video should include information on recognizing signs and symptoms of autism spectrum disorder and contacts for information on appropriate responses to those individuals.

Section 3 directs the School of Government (SOG), in consultation with the Autism Society of NC, TEACCH, and other organizations, to study and determine additional training needs to ensure appropriate responses to persons with autism within the legal system. The section further directs the SOG to develop a proposal for funding and delivering the necessary training and report to the Joint Study Committee on Autism Spectrum Disorder and Public Safety by October 1, 2008.

EFFECTIVE DATE: The act is effective when it becomes law.

BACKGROUND: Between January and June 2008, North Carolina issued 34 Silver Alerts. Of those 34 alerts 31 were found unharmed[1]. This is a recommendation of the Joint Study Committee on Autism Spectrum Disorder and Public Safety.

H2523e2-SMSQ

[1] http://www.nccrimecontrol.org/div/ale/missingpersons/Silver_Alert_Activations.xls

VISITOR REGISTRATION SHEET

Senate Health Care — **July, 2, 2008**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Liz Hoffman	NCAFT
Christina Appleton	NCMB
Tom Winton	NC Dept. of Public Instruction
Claire Greer	NC Dept. of Public Instruction
Paula Hudson Collins	NS State Board of Education

VISITOR REGISTRATION SHEET

Senate Health Care
Name of Committee

July, 2, 2008
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
James Gheen	Intern For Senator Doug Berger
Thomas C. Caves, Jr.	NC Dept. of Crime Control & Public Safety

SENATE COMMITTEE ON HEALTH CARE

MINUTES
JULY 9, 2008

The Senate Committee on Health Care held a meeting in Room 544 on July 9, 2008 and considered one bill.

The meeting was called to order by Senator Purcell, Co-Chair, and he announced consideration of House Bill 2410 AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF AGING AND ADULT SERVICES, AND DIVISION OF MEDICAL ASSISTANCE TO STUDY IMPLEMENTATION OF AN INCOME DISREGARD POLICY FOR CURRENT STATE/COUTY SPECIAL ASSISTANCE AND MEDICAID RECIPIENTS WHO ARE ADVERSELY IMPACTED DUE TO COST OF LIVING OR OTHER INCOME INCREASES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING. (Attachment 1)

Bill sponsor, Representative England, was called upon to explain the bill, and a copy of that explanation is included with these minutes as Attachment II. The bill received a favorable report upon motion of Senator Malone and was reported out of Committee the same day.

Senator Purcell then adjourned the meeting.

Respectfully submitted,

Becky Hedspeth

Becky Hedspeth, Committee Clerk

William R Purcell

Senator William R. Purcell, Co-Chair

Becky Hedspeth (Sen. Purcell)

From: Becky Hedspeth (Sen. Purcell)

Sent: Monday, July 07, 2008 5:01 PM

To: @Senate Principal Clerk's Office; @Senate/Health Care; @SenateCommitteeNotice; Anna Kidd (Sen. Blake); Ben Popkin (Research); Bonnie McNeil (Sen. Malone); Carol Resar (Sen. Atwater); Carole Walker (Sen. Allran); Dee Hodge (Sen. Dannelly); Evelyn Costello (Sen. Rand); Evelyn Hawthorne; Genie Clark (Sen. Brunstetter); Gerry Johnson (Sen. Hartsell); Glenn Jernigan; Interested Persons; Irma Avent-Hurst (Sen. Edward Jones); Jack Register, MSW, LCSW; Jackie Ray (Sen. Foriest); Janette Lee (Sen. Nesbitt); Judy Chriscoe (Sen. Bingham); Kathie Young (Sen. Kinnaird); linda laton; Lorraine R. Blake; Mary Watson Cannon (Sen. Forrester); Nancy Fox (Sen. Jacumin); Penny Williams (Sen. Hoyle); Phyllis Cameron (Sen. Dorsett); Public Distribution List; Roger Berliner; Sharon Pearce; Shawn Parker (Research); Steve Shore; Susan Barham (Research)

Cc: Rep. Bob England; Rep. Jean Farmer-Butterfield; Rep. Alice Bordsen; Rep. Garland Pierce

Subject: Senate Health Care 7/9/08

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	July 9, 2008	11:00 AM	544

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB2410	Special Asst. Income Disregard Study	Rep. England

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

HEALTH CARE MEETING
AGENDA

July 9, 2008
Room 544

HB 2410 **Special Asst. Income Disregard Study.**

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 2410*

Short Title:	Special Asst. Income Disregard Study.	(Public)
Sponsors:	Representatives England, Farmer-Butterfield, Bordsen, Pierce (Primary Sponsors); and Harrison.	
Referred to:	Aging.	

May 26, 2008

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF AGING AND ADULT SERVICES, AND DIVISION OF MEDICAL ASSISTANCE, TO STUDY IMPLEMENTATION OF AN INCOME DISREGARD POLICY FOR CURRENT STATE/COUNTY SPECIAL ASSISTANCE AND MEDICAID RECIPIENTS WHO ARE ADVERSELY IMPACTED DUE TO COST OF LIVING OR OTHER INCOME INCREASES, 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 Division of Medical Assistance shall study implementation of an income disregard policy for current State/County Special Assistance and Medicaid residents who are adversely impacted due to cost of living or other income increases.

SECTION 1.(b) The Department of Health and Human Services, Division of Aging and Adult Services, and Division of Medical Assistance shall report the findings and recommendations of the study contained in this section to the Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services, on or before October 1, 2009.

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

HOUSE BILL 2410:
Special Asst. Income Disregard Study

BILL ANALYSIS

Committee:	Senate Health Care	**Date:**	July 8, 2008
Introduced by:	Reps. England, Farmer-Butterfield, Bordsen, Pierce	**Summary by:**	Shawn Parker Legislative Analyst
Version:	First Edition		

SUMMARY: ***House Bill 2410 directs the Divisions of Aging and Adult Services and Medical Assistance, DHHS, to study implementation of an income disregard policy for current State/County Special Assistance and Medicaid recipients adversely impacted to due to income increases.***

BILL ANALYSIS: House Bill 2410 directs the Division of Aging and Adult Services and the Division of Medical Assistance, Department of Health and Human Services, to study implementation of an income disregard policy. The study would determine if the State can implement an income disregard policy for current State/County Special Assistance and Medicaid residents that are adversely impacted due to cost of living or other income increases.

The Department is required to report findings and recommendations from the study on or before October 1, 2009, to the Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services.

The bill would become effective when it becomes law.

BACKGROUND: State/County Special Assistance (SA) is a Supplemental Security Income (SSI) State supplement that pays cash benefits to eligible recipients residing in licensed facilities that are authorized to receive SA payments. State/County Special Assistance is 50% county dollars and 50% State dollars.

Department of Social Services caseworkers work with individuals to determine eligibility. According to the Department of Health and Human Services, Special Assistance/Adult Care Home (SA/ACH) is available to otherwise eligible applicants with a monthly income of $1,218.50 or less and who have savings and assets worth less than $2,000. Countable income includes wages, Social Security and SSI, retirement income and Veteran's Administration income. Assets that are considered include: property, cash, savings, checking accounts, stocks, bonds, annuities, some IRAs, and the cash value of life insurance policies.

Special Assistance payments are tied to the maximum rate adult care homes can charge SA recipients for room and board. Effective January 1, 2009, the maximum rate set by the General Assembly will be $1,207 (currently $1,173).

The SA rate for an individual is determined by taking the maximum adult care home rate, adding a personal needs allowance of $46 dollars to allow for clothes and other essentials each month, and subtracting out net countable monthly income. The resulting amount is payment to the adult care home for room and board.

On occasion, individuals receive cost of living increases to their source of income and may no longer be eligible for SA, even though they could be only slightly above the threshold.

State/County Special Assistance recipients that live in an adult care home are automatically eligible for Medicaid. Medicaid provides coverage for personal care services and other services provided by Medicaid.

Because SA/ACH recipients are automatically eligible for Medicaid, North Carolina must explore implications of such a policy change with the Centers for Medicare & Medicaid Services, through the Division of Medical Assistance, and with the Social Security Administration.

Theresa Matula, staff to House Aging, substantially contributed to this summary.

H2410e1-SMSQ

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, July 09, 2008

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

FAVORABLE

H.B. **2410** Special Asst. Income Disregard Study.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments: