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## Health

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In 2004 the issues of public health and access to health care were front and center on the legislative agenda. Funding was restored to several existing programs and new funding streams and initiatives were launched, including the School Health Nurse Initiative, the Public Health Incubator program, and a new Community Health Grant fund.

Several of these initiatives were derived from the recommendations included in the interim report of the Public Health Task Force 2004. The Task Force was convened by the North Carolina Department of Health and Human Services (DHHS) and included representatives from the local and state public health communities, legislators, community leaders, and others. The task force's report included eighteen recommendations related to the infrastructure of the public health system and core service gaps across the state.<sup>1</sup> The group is expected to continue deliberating, and additional recommendations may become legislative proposals in the coming years.

### **Budget**

#### **Public Health**

Two major funding initiatives in the 2004 appropriations act [S.L. 2004-124, (H 1414)] focus exclusively on the public health community; one infuses money into an existing program, and the other establishes an entirely new program. First, funding for the AIDS Drug Assistance Program (ADAP) was increased by over \$2.7 million to purchase prescription drugs to treat HIV and AIDS. Individuals with family incomes of less than 125 percent of the federal poverty level (\$11,600 for a family of one) may be eligible for the program. Before this funding increase, North Carolina had the longest ADAP waiting list in the country. The increased funding will allow enrollment of all the individuals on the waiting list as well as other eligible individuals. In addition to the funding increase, Section 10.31 of the 2004 appropriations act directs DHHS to study whether the adoption of a six-month eligibility process would save the program money in the future.

To establish and administer a new "public health incubator" program, the North Carolina Institute for Public Health at the UNC School of Public Health will receive over \$1 million. The incubator program is intended to promote regionalism in public health activities across the state

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1. The task force's interim report is available online at <http://www.dhhs.state.nc.us/dph/taskforce/taskforce.htm>.

and collaboration between public health departments, other government agencies, and nonprofit organizations. The new program arises from recommendations of the Public Health Task Force. The task force recognized the success of a regional partnership launched in the northeastern region of the state in 1999 and suggested that funding be made available to encourage other models of cooperative regional planning and service delivery. The new funding must be used for specific purposes, including the following:

- Building capacity for activities related to disease surveillance and health disparities
- Conducting regional health assessments and identifying priorities
- Raising public awareness about health-related issues
- Providing additional training to board of health members
- Evaluating workforce preparedness

DHHS must submit an evaluation of the incubator program to the General Assembly by January 2005.

By comparison, a relatively small sum (\$50,000) was allocated to the DHHS Division of Public Health (DPH) for distribution to those health departments that are officially accredited as a result of a pilot accreditation program established last year. The funds may be used for a wide range of activities, including the following:

- Appointing quality improvement officials in each department
- Developing new partnerships
- Providing incentives for regional collaboration, including the creation of district health departments and public health authorities
- Assisting other public health departments seeking accreditation
- Strengthening the role of local boards of health

An additional \$50,000 was allocated to the North Carolina Institute for Public Health to establish the Pilot Accreditation Advisory Board. The Board must evaluate the new accreditation process and report its findings. The General Assembly directed DHHS to expand the current pilot accreditation process to include additional counties and also to continue the work of the Public Health Task Force.

Several other public health programs also received new or increased funding for the coming fiscal year. Recurring funds were allocated to several programs that suffered cuts in past years, including the Child Fatality Task Force (\$69,429, including the creation of one new position), the Women, Infants, and Children (WIC) Farmers Market Program (\$156,630), and Prevent Blindness (\$41,900). Nonrecurring funds were allocated to the Healthy Start Foundation for the prevention of infant mortality and morbidity (\$225,000), the University of North Carolina Children's Communicative Disorder Program (\$177,000), and the Arthritis Prevention Program (\$25,000).

The General Assembly also provided for fifty-three new positions within various DPH programs and one position dedicated to bioterrorism preparedness within the Division of Facility Services. Positions are to be supported almost entirely by receipts from outside sources such as the Centers for Disease Control and the U.S. Department of Homeland Security.

While funding for public health programs increased overall, a few programs did suffer reductions, including the Early Intervention Children's Development Services Agencies (\$250,000), the Office of the Medical Examiner (\$25,000), and the State Center for Health Statistics (\$10,000). In addition, state funding for health promotion activities was reduced by \$159,000. However, federal funding for health promotion through the Preventive Services Block Grant is expected to increase in the coming years.

### **School Nurses**

One of the most significant new funding streams in this year's appropriations act will fund the creation of the School Health Nurse Initiative, another program recommended by the Public Health Task Force. The initiative, managed by the DHHS Division of Public Health (DPH) and the Department of Public Instruction (DPI), will provide funds to communities across the state to hire a total of 145 school nurses. The legislature appropriated \$4 million in recurring state funds to

hire 80 new nurses. In addition, Section 5.1(cc) of the appropriations act earmarks \$6.5 million from the federal Maternal and Child Health Block Grant to hire 65 school nurses on a time-limited basis. When allocating funds the departments must consider, among other things, current nurse-to-student ratios, the economic status of targeted communities, and the health needs of area children. On August 18, 2004, the Governor's office issued a press release identifying the local education agencies that will receive the funding for new nurse positions.

### **Community Health**

The budget earmarked \$7 million in nonrecurring funds for a new DHHS competitive grant program. The funds are intended to increase access to care for uninsured and medically indigent patients by

- expanding services provided by health centers currently serving these populations;
- establishing new health centers in counties without them; and
- increasing capacity at current centers by enhancing or replacing facilities, equipment, or technologies.

Of the total grant funds, \$5 million must be used for community health centers (that is, federally qualified health centers [FQHCs] and FQHC look-alikes) and \$2 million must be used for rural health centers and public health departments. DHHS is required to work closely with the North Carolina Community Health Center Association and the North Carolina Public Health Association in developing the evaluation process. The grant program should generate some interesting data because grant recipients must submit annual reports to DHHS regarding the care provided to uninsured and medically indigent patients. DHHS is required to report to the General Assembly in 2005 regarding the need for continuing funds for the grant program.

### **Medicaid and Health Choice**

Funding and programmatic changes related to the Medicaid and Health Choice programs are addressed in Chapter 21, "Social Services."

## **Public Health**

### **Confidentiality**

North Carolina local health departments are required by state and federal law to maintain the confidentiality of patient medical records. The federal HIPAA privacy regulation<sup>2</sup> is the most comprehensive law governing confidentiality, but several state laws also apply. Under HIPAA local health departments may share identifiable health information with others for purposes of treatment, payment, and health care operations without obtaining written permission from the patient (or the patient's legal representative). State law, however, has limited the types of information local health departments can share with others for these three purposes. For example, under G.S. 130A-143 health departments could share only limited information for payment purposes when that information related to a reportable communicable disease, such as HIV or tuberculosis. As a result, in these situations health departments have had to obtain written permission from patients to disclose information for treatment, payment, and health care operations purposes.

Obtaining such permission presents unique challenges for local health departments because they are legally obligated to care for individuals in their counties in several circumstances. For example, if a person infected with a communicable disease comes to a health department, the

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2. HIPAA is the Health Insurance Portability and Accountability Act of 1996. All local health departments in North Carolina were required to come into compliance with the HIPAA privacy regulations by April 14, 2004. *See* 45 C.F.R. Parts 160 and 164.

department is legally required to care for that person. If the person refuses to sign the permission form allowing the health department to disclose information for purposes of treatment, payment, or health care operations, the department finds itself in a difficult position: it must provide care, but it may not share the information necessary to obtain payment for that care (such as reimbursement from Medicaid) and it may not share information related to the person's treatment with other health care providers. To resolve this dilemma, the General Assembly amended a state confidentiality law, G.S. 130A-12, to authorize health departments to disclose information for purposes of treatment, payment, and health care operations [S.L. 2004-80, (S 582)]. Such disclosures are further restricted by HIPAA and other state law, but this amendment assures local health departments that they may disclose most health information for these three purposes in most situations without written permission.<sup>3</sup>

### **Public Health Preparedness**

In 2002 the General Assembly enacted S.L. 2002-179, which included several new provisions intended to enhance state and local public health officials' preparedness for emergencies, particularly bioterrorism-related emergencies. This session several adjustments to the new laws were adopted as part of S.L. 2004-80. The first involves a change to the definition of *isolation authority* in G.S. 130A-2(3a). The term previously encompassed only persons and animals actually infected with a communicable disease or condition. The revised definition extends the scope of the term to include persons and animals "reasonably suspected" of being infected with a communicable disease or condition. Among other things, this expanded definition will allow state and local public health officials to exercise their authority in emergent situations where confirmed diagnoses may not be readily available.

The next series of changes relates to the procedures and time frames applicable when a local health director or the State Health Director exercises quarantine or isolation authorities to limit a person or animal's freedom of movement or to limit access to a person or animal. When the law was amended in 2002, the General Assembly incorporated significant due process protections for persons and animals affected by quarantine or isolation orders limiting freedom of movement or access. For example, the 2002 law added new language to G.S. 130A-145 to provide that an initial order would be valid for only ten days and the health director would have to go to court to have it extended for successive periods of up to thirty days. After the implementation of the 2002 law, health officials recognized that to contain the spread of some diseases such as Severe Acute Respiratory Syndrome (SARS), initial orders limiting movement or access should be effective for periods longer than ten days. Officials concluded that the extension procedures could become unwieldy if the officials were required to pursue extensions for hundreds or thousands of people in the event that North Carolina experienced a SARS outbreak similar to that of Toronto in 2003. They thus appealed to the General Assembly for an extension of the initial period limiting freedom of movement or access. The 2004 amendments extend this period from ten to up to thirty days.

After the initial limitation, local and state health directors may still ask a court to extend the limitation for additional periods of up to thirty days each. S.L. 2004-80 amends the law to require the court order to provide for automatic termination of the limitation if a health official determines that the quarantine or isolation is no longer necessary. It also provides the subject of the limitation (that is, the person or the owner of an animal) with the opportunity to prove to the court that the order should be terminated before the established expiration date. A special time frame applies when a person infected with tuberculosis has had his or her freedom of movement limited. In those cases the court is authorized to extend the order for up to a year at a time. This longer period reflects concern about a drug-resistant strain of tuberculosis, a disease that can present a public

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3. At least two exceptions apply. State regulations require health departments to obtain written permission to (1) bill a third-party payer for HIV testing or counseling and (2) disclose HIV/AIDS-related information for treatment purposes when the department has *not* provided direct medical care to the patient. 10A NCAC 41A .0202(9) and (11).

health threat indefinitely. As with other cases, a person with tuberculosis who is subject to a longer limitation may at any time ask the trial court to reconsider its order and seek termination of the order before the established expiration date.

In 2002 similar due process protections were also incorporated into G.S. 130A-475, one of the sections added to address public health activities in the context of suspected terrorist attacks involving nuclear, biological, or chemical agents (hereinafter bioterrorism). S.L. 2004-80 amends those protections to extend the initial period for limiting freedom of movement or access from ten to up to thirty days. Technical changes to the 2004 provisions were included in Section 33 of S.L. 2004-199 (S 1225).

S.L. 2004-80 adds a new due process protection to both G.S. 130A-145 and G.S. 130A-475. Whenever a health official exercises his or her authority to limit freedom of movement or access under either of these two sections, the official is now required to provide notice to certain individuals about their rights to have the limitation reviewed by a court.<sup>4</sup> The official must provide notice to any person the official knows is substantially affected by the limitation.

S.L. 2004-80 adds or modifies several other provisions related to public health preparedness. New G.S. 130A-141.1 gives the State Health Director the authority to issue a temporary order requiring health care providers to report health-related information in order to conduct a public health surveillance or an investigation. Such an order may be appropriate if, for example, a new communicable disease may be emerging (such as when SARS first appeared) and public health officials need to track the number of people experiencing certain symptoms to determine how and where the disease is spreading and to develop an appropriate response. These temporary orders may be valid for up to ninety days. After that time the Commission for Health Services has the authority to adopt rules continuing the reporting requirement if necessary.

S.L. 2004-80 also revises two public health laws concerning the authority of state and local officials to access medical and other records. The law amends G.S. 130A-144(b), a general provision in the state's communicable disease control law requiring physicians and medical facilities to provide to the State Health Director or a local health director access to medical records upon request. The new law makes two significant changes to this provision. First, providers and facilities must now provide access to *any* records (rather than only medical records) the state or a local health director determines are relevant to the public health inquiry. The second amendment relates to the scope of the records request. Prior to the amendment, the law required that access must be provided only to records pertaining to the care of a patient infected with, exposed to, or reasonably suspected of being infected with or exposed to a communicable disease or condition. The section was amended so that the health directors may also have access to information pertaining more generally to the investigation of a known or suspected outbreak of a communicable disease or condition. The request for access apparently does not need to be directly related to an infected or exposed individual. This more expansive authority could be useful to health officials investigating a new or emerging illness and attempting to identify clusters of symptoms or conditions present in a community.

The other access provision amended by S.L. 2004-80 concerns bioterrorism-related investigations. Language added to G.S. 130A-476(c) provides more expansive authority for records requests by state and local officials, consistent with the new authority in G.S. 130A-144(b), described above. Under the revised law, state and local health directors may demand records necessary to deal with a case or an outbreak of a disease that may have been caused by a bioterrorism-related incident. Language was also added to clarify the authority of state and local health directors with respect to access requests. G.S. 130A-476(c) previously stated that these officials "may request" access to certain records of health care providers, health care facilities, and laboratories. Some providers questioned whether such language ("may request") required them to provide access upon request

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4. Under the 2002 law, such persons were given the right to institute an action to have the limitation reviewed in superior court in Wake County or in the county where the limitation was imposed.

or whether compliance with the requests was optional. The amendments clarify that these entities are indeed required to disclose records to the state or local health officials who request them.

The 2004 appropriations act modifies another provision of the 2002 bioterrorism law. The original version of G.S. 130A-476(f) authorized the State Health Director to collect voluntarily provided data from hospital emergency rooms and urgent care centers in order to conduct public health surveillance. Some health care providers, however, were reluctant to provide such data because of concerns that the disclosure would violate state medical confidentiality law. Section 10.34 of the 2004 appropriations act repealed that provision and added new G.S. 130A-480, which requires the State Health Director to develop a hospital emergency room surveillance program to facilitate the detection of epidemics, diseases (such as communicable diseases), and bioterrorism-related threats. The new law expressly *requires* hospitals to submit emergency room data to the surveillance system as directed by Commission for Health Services rules. To protect patient privacy, the law limits the types of identifiers the State Health Director may collect. For example, he or she may not collect patient names, social security numbers, or account numbers. In addition, the Director must protect the confidentiality of all data collected through this program, and the data is exempt from the state public records laws.

### **Nutrition**

Section 7.17 of the 2004 appropriations act directs the State Board of Education to establish a pilot program to support the efforts of eight school systems to provide only healthful, nutritious food choices to elementary school students. The Board may reimburse the pilot systems for any loss in food service revenues during the 2004–2005 school year resulting from the implementation of a healthful school food program.

### **Early Intervention Services**

North Carolina offers two Early Intervention programs to provide an array of services to children with special needs from birth to age five. Section 10.9 of the 2004 appropriations act directs DPH to track and report on the number of children referred to the Early Intervention programs through Department of Social Services abuse and neglect agents.

### **Environmental Health**

Two pieces of recent legislation will directly affect local environmental health programs. S.L. 2004-178 (S 1054), which primarily focuses on enhancing penalties for crimes associated with the manufacture and distribution of methamphetamine, added a provision to the public health laws related to decontamination of property used for manufacturing the drug. New G.S. 130A-284 directs the Commission for Health Services to adopt rules establishing standards governing decontamination of residences and places of business where the drug was manufactured. If the property owner, lessee, operator, or other person in control of the property knows that the property was used for drug manufacturing, that person is required to comply with the commission's decontamination standards (and presumably assume the cost of any decontamination). The law does not specify who, if anyone, will be responsible for compliance with the decontamination standards if the property owner or other person did not have any knowledge regarding the illegal use of the property.

The second piece of environmental health-related legislation involves subsurface wastewater disposal systems (septic systems). In response to the concerns of some coastal counties, the General Assembly adopted a change to the law regulating the required distance between residential septic systems. The modification included in S.L. 2004-140 (S 1202) applies only if the following conditions are satisfied:

- The lot's deed or plat was recorded before July 1977.
- The lot is too small to accommodate the setback requirements included in current wastewater regulations.
- The system will support a single-family dwelling with no more than four bedrooms.
- No public or community wastewater alternative is available.
- The system will be installed in certain types of sandy soils.

The setback requirement for systems satisfying these conditions is ten feet; the requirement for other systems is twenty feet. The law authorizes the Commission for Health Services to adopt rules incorporating these requirements and provides that the law expires once the commission's permanent rules become effective.

## Quality Assurance and Peer Review

S.L. 2004-149 (H 669) made several changes to Chapter 131E provisions governing hospitals and other health care providers. It defines a new term in G.S. 131E-101: *quality assurance committee*. The term encompasses peer review corporations or organizations as well as committees or other organizations affiliated with hospitals, nursing homes, and adult care homes formed to evaluate the quality or cost of or necessity for health care services under applicable laws. The law also revises the definition of *medical review committee* to refer to several different types of committees formed to evaluate the quality or cost of or the necessity for hospitalization or health care, including committees of state or local professional societies, hospital medical staffs, and peer review corporations or organizations.

The legislation also amended G.S. 131E-107 to extend immunity from civil liability to members of quality assurance committees. The immunity only extends to statements and actions falling within the scope of the members' quality assurance activities. This same immunity was already applicable to activities of medical and peer review committees. In addition, G.S. 90-21.22A now shields quality assurance committees (as defined in that section) from medical malpractice liability for committee statements and activities.

New language was also added to G.S. 131E-107 to protect the confidentiality of the materials of all three types of committees. This section also now provides that information forwarded by the committees to the Joint Commission on Accreditation of Healthcare Organizations remains confidential. The law clarifies that information otherwise available is not shielded from discovery simply because it was considered by a quality assurance, medical, or peer review committee. It also specifically provides that public records do not become confidential simply by virtue of being considered by the committee. Finally, the new law provides that committee members may not be compelled to testify about information related to committee proceedings. Similar changes were also incorporated into G.S. 131D-21.2, which regulates adult care and maternity homes.

For changes related to peer review activities of facilities licensed under Chapter 122C, see the discussion in Chapter 16, "Mental Health."

## Health Professions

### Liability

S.L. 2004-149 adds a new section to Chapter 90 to shield medical directors of nursing homes from liability in certain circumstances. Directors may still be named in lawsuits when the allegations relate either to a patient under his or her direct care or to the director's conduct in a supervisory or consulting role.

The law also adds a new section to the North Carolina Rules of Evidence. Under new Section 413, statements by a health care provider apologizing for an adverse outcome in a medical treatment or offering to undertake corrective or remedial treatment or actions are not admissible to prove

negligence or culpable conduct in a medical malpractice action against the provider. Information about a provider's gratuitous acts to assist affected persons is also not admissible in such actions.

### **Pharmacies**

Under G.S. 90-85.21A(a), out-of-state pharmacies dispensing legend drugs into the state (via mail or otherwise) are required to register with the North Carolina Board of Pharmacy. S.L. 2004-199 amends the requirement to provide that, as part of the registration, such pharmacies must certify that they employ pharmacists who meet licensure requirements equivalent to those of North Carolina. The pharmacist must agree to be subject to the jurisdiction of the Board of Pharmacy.

### **Physician Assistants**

Ordinarily, a physician assistant licensed in North Carolina is authorized to dispense drugs if he or she does so under the supervision of a licensed pharmacist and complies with the rules of the North Carolina Board of Pharmacy. S.L. 2004-124 adds new G.S. 90-18.2A, which creates an exception to this general rule. The law provides that the North Carolina Medical Board (rather than the Board of Pharmacy) has sole jurisdiction to regulate and license physician assistants who receive, prescribe, or dispense prescription drugs without charge or fee to the patient, provided the physician assistant is working under the supervision of a licensed physician.

### **Drug Assistance Program**

Seniors in North Carolina now have at least two governmental prescription drug programs available to help them pay for medicines. The state offers some low-income seniors the option of enrolling in the Senior Care Prescription Drug Assistance Program (Senior Care), which provides a prescription drug benefit up to \$600 per year. In addition, the federal government recently approved a program through which Medicare beneficiaries may obtain and use a drug discount card until the full Medicare prescription drug benefit is implemented in 2006. The Medicare prescription drug program also provides a \$600 benefit for some low-income seniors. To ensure the two programs are well-coordinated and that the federal Medicare dollars are exhausted before state dollars are used, S.L. 2004-124 provides the state program the authority to automatically enroll into the Medicare drug discount program any senior participating in the state Senior Care program. The state must provide the senior an opportunity to opt out of such an enrollment.

### **Studies**

The studies act of 2004, S.L. 2004-161 (S 1152), authorizes and requires several studies related to health and health care. The Legislative Research Commission is authorized to study issues including the following:

- High-risk health insurance pools and health insurance mandates
- Availability of health insurance to small businesses, trade associations, and individuals who have difficulty obtaining coverage
- The practice of naturopathy in the state
- Care and safety of residents in residential care facilities

The Joint Legislative Health Care Oversight Committee is authorized to study issues including the following:

- Alternative benefit plans for dependents of state employees
- Establishment of one or more public entities to perform functions such as purchasing health care services provided with state funds, negotiating the cost of prescription drugs, and consolidating data and processing claims
- Internet sale of prescription drugs
- Pain management and palliative care
- Medical errors

The act directs the Commission for Health Services to evaluate the possibility of implementing a pilot program related to innovative peat-based on-site wastewater systems.

The law also establishes a new study commission that will focus on Health Care Workforce Development. The commission is expected to determine methods for increasing the number of people providing health and dental care in North Carolina and submit its final report to the 2006 session of the General Assembly.

## **Other Laws of Interest**

### **Health Insurance Innovations Commission**

In S.L. 2004-175 (S 1202), the General Assembly established the Health Insurance Innovations Commission, which will focus on the availability of health insurance to small businesses in North Carolina. The commission's responsibilities include evaluating the health insurance environment for small businesses, initiating regional demonstration projects to pilot innovative health plans and products, and developing recommendations for changes to the current insurance climate. The commission's plans and products must be approved by the state Commissioner of Insurance.

### **Rebirthing**

In April 2000 a North Carolina child died after undergoing a "rebirthing" procedure in Colorado, a procedure intended to reenact the birthing process. As a result the 2003 General Assembly criminalized such rebirthing procedures. This year's budget bill (S.L. 2004-124) amended the criminal statute (G.S. 14-401.21) to further provide that no state funds may be used to pay for rebirthing procedures performed in other states.

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