

Health

During 2008 the General Assembly considered health-related legislation covering a wide variety of topics, including the regulation of smoking in public places, the sale of unpasteurized milk to the public, and the donation of anatomical gifts. Most of the legislation enacted produced relatively minor changes to existing state laws, but the General Assembly did establish two significant new reporting requirements—one related to childhood injuries and another related to race and ethnicity of patients. In addition, the appropriations process resulted in significant increases in funding for local public health services, both in the form of grant programs and direct aid to counties and in various public health initiatives.

Public Health

Budget

The 2008 appropriations act, S.L. 2008-107 (H 2436), makes several significant changes to funding allocated to the Division of Public Health within the North Carolina Department of Health and Human Services (DHHS). Recurring funding is appropriated as follows:

- \$4.8 million in direct aid to local health departments, which increases the total direct aid amount to over \$11 million.
- \$1 million in grant funding for community programs seeking to prevent chronic illness among minority populations.
- \$500,000 for the tobacco quitline, which is a telephone-based education, counseling, and support service intended to help individuals quit using tobacco.
- \$500,000 for a grant-in-aid to the Healthy Start Foundation, which is a nonprofit organization focused on reducing infant mortality and other women's and children's health issues.

- Over \$300,000 to the Office of the Chief Medical Examiner to add positions to support increased reporting requirements and to manage a backlog in the toxicology laboratory.
- \$100,000 to fund family planning for uninsured women who are not eligible for Medicaid.

In addition, the appropriations act provides for nonrecurring funding for several public health programs, including:

- \$4 million in nonrecurring grant funding for safety net providers, including rural health centers, local health departments, free clinics, school-based health centers, and others.
- \$2 million for comprehensive demonstration projects focused on reducing obesity and chronic diseases caused by obesity.
- \$450,000 for various purposes related to stroke prevention and rehabilitation.
- Over \$400,000 to the Healthy Carolinians program.
- \$400,000 for programs related to an initiative focused on adolescent pregnancy prevention, school dropout prevention, and teen parenting.
- Almost \$250,000 for a program designed to (1) improve birth outcomes by educating women about the benefits of progesterone and purchasing medication for women at risk for preterm births and (2) reducing infant mortality through the implementation of a safe sleep public awareness campaign.
- \$150,000 for a grant-in-aid to Prevent Blindness North Carolina to expand the prekindergarten vision screening program.

S.L. 2008-107 also reduces some of the Division of Public Health's appropriations from last year, including reductions to the following:

- Operating funds (\$1.9 million) and contracts (\$2 million).
- State Public Health Laboratory (over \$400,000).
- Women, Infants, and Children Program (WIC) (over \$300,000).
- Vision Care Program (\$500,000).
- Breast and Cervical Cancer Program (\$500,000).

Other provisions of the budget that directly impact public health providers include:

- An appropriation of \$2.8 million in recurring and \$950,000 in nonrecurring grant funding to support provider networks that coordinate free care for low-income and uninsured patients.
- \$250,000 in nonrecurring grant funding for the expansion of school-based health centers.
- Authorization for the Aids Drug Assistance Program (ADAP) to serve individuals with incomes up to 300 percent of the federal poverty level, rather than 250 percent.
- A requirement that DHHS use \$100,000 from the Maternal and Child Health Block Grant to establish a Task Force on Preventing Childhood Obesity.

Smoking

In 2007 the General Assembly enacted G.S. 130A-493, which prohibits smoking in state government buildings and allows local governments to regulate smoking in local government buildings and a few other public places. S.L. 2008-149 (S 1681) amends G.S. 130A-493 to extend the prohibition on smoking to state vehicles. A *state vehicle* is defined as “any passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or state agency or institution for official State business.” The legislation directs the person in charge of assigning the vehicle to post “no smoking” signs in conspicuous areas of the vehicle, except if the vehicle is used for undercover law enforcement operations. The legislation also amends G.S. 130A-498 to allow local governments to regulate smoking in local government vehicles.

Several years ago, community colleges were granted an exception to a law that had previously restricted their ability to prohibit smoking in their buildings and on their grounds.¹ Relying upon this exception, many community colleges adopted policies prohibiting smoking on their campuses, including on their campus’ grounds. When the General Assembly passed legislation last year allowing local governments to restrict smoking in local government buildings, the authority of community colleges to restrict smoking was arguably diminished.

1. S.L. 2006-133 (amending G.S. 143-599).

Because it appeared that community colleges fell within the definition of “local government,” the colleges would have the authority to regulate smoking only inside their buildings and not on their grounds. In 2008 the General Assembly enacted S.L. 2008-95 (S 1669) amending G.S. 130A-498 to clarify that the term “local government” did not include community colleges in the context of smoking laws. It also adds new G.S. 115D-20.1 to the General Statutes Chapter governing community colleges. The new section authorizes a local community college’s board of trustees to adopt, implement, and enforce a written policy prohibiting tobacco use in college buildings, in college facilities, on college campuses, in college vehicles, at college-sponsored events, and on any other property owned, leased, or operated by the college. The language in the new law is similar to the language authorizing local school officials to adopt tobacco-related policies.²

Another piece of legislation also included a smoking-related provision. Section 10.4B of S.L. 2008-107 adds new G.S. 90-18.6, which governs state-funded nicotine replacement therapy programs. The new provision authorizes the Health and Wellness Trust Fund or DHHS to contract for the operation of a tobacco-use cessation program. Under the contract the program can recommend over-the-counter nicotine replacement therapy products to individuals, counsel them about the products (e.g., contraindications), and provide the products free of charge. The law stipulates that any medical aspects of the program must be supervised by a licensed physician.

Unpasteurized Milk

The General Assembly has the authority to disapprove rules adopted by administrative rulemaking bodies, such as the Commission for Public Health and the Environmental Management Commission. In S.L. 2008-88 (H 2524) the legislature exercises this authority by disapproving rules adopted by the North Carolina Board of Agriculture in 2007. The board’s rules would have required unpasteurized milk, which is currently allowed to be distributed as commercial feed, to be dyed gray with food coloring and labeled “NOT FOR HUMAN CONSUMPTION.”³ The expectation was that the dying and labeling of the milk would discourage human consumption of unpasteurized, or raw, milk. In lieu of the rules, the legislature amended G.S. 130A-279, the public health law that already prohibits the sale or dispensing of unpasteurized milk directly to consumers for human consumption. The statute now requires that raw milk dispensed as animal

2. See G.S. 115C-407.

3. 22 North Carolina Register 1028 (December 3, 2007) (reprinting the text of 02 N.C.A.C. 09E .0116 as adopted by the North Carolina Board of Agriculture and approved by the Rules Review Commission).

feed include a warning statement explaining that (1) the milk is not for human consumption, and (2) it is illegal to sell raw milk for human consumption in the state.

Drinking Water Wells

In 2006 the General Assembly adopted legislation requiring local health departments to begin issuing permits for the construction and repair of private drinking water wells.⁴ The new permitting requirements went into effect on July 1, 2008. As part of the permitting program, the law requires that the water from permitted private drinking water wells be sampled and tested for several different parameters. S.L. 2008-198 (S 845) expands the list of parameters in G.S. 87-97(h) to include methyl tert-butyl ether, ethylene dibromide, 1,2-dichloroethane, 1,2-dichloropropane, isopropyl ether, benzene, toluene, ethylbenzene, xylenes, trichloroethylene, and tetrachloroethylene. These additional testing requirements will go into effect October 1, 2009.

Public Health Incubator Program

In 1997 several local health departments in northeastern North Carolina joined together in an effort to improve public health services in their region. They formed a group, called the Northeastern North Carolina Partnership for Public Health. The partnership served as a model for what are now called public health incubators—voluntary collaborations among local health departments and other community groups that are intended to “hatch” new ideas leading to improved public health practices. Since 2004 the General Assembly has provided funding to the North Carolina Institute for Public Health to support the public health incubator program.⁵ S.L. 2008-92 (S 1687) directs the program to report annually to the Public Health Study Commission; the first report was due October 1, 2008. The annual reports must address how the program is achieving its mission of supporting the voluntary collaborations and regional health needs and discuss the program’s efforts to address the urgent public health needs identified in the Public Health Task Force’s 2008 Public Health Improvement Plan.⁶

4. S.L. 2006-202 (amending G.S. Chapter 87).

5. Sec. 10.32 of S.L. 2004-124.

6. The Public Health Task Force studies public health in North Carolina and creates plans intended to strengthen public health infrastructure and improve health outcomes in the state. The Task Force’s 2008 Public Health Improvement Plan is available online at www.ncpublichealth.com/taskforce/taskforce-2008.htm.

Early Intervention Services

The Early Intervention Branch, part of the Division of Public Health, works in conjunction with other state agencies to provide services to children under age five who have disabilities or other special needs. The work of the branch and other state agencies is overseen by the NC Interagency Coordinating Council. Some early intervention services are provided through regional children’s developmental services agencies (CDSA). In 2003 the General Assembly established eighteen Regional Interagency Coordinating Councils to serve each of the eighteen CDSA catchment areas and charged them with developing early intervention plans for their regions. S.L. 2008-85 (H 2127) repeals G.S. 143B-179.5A, the statute that created the regional councils. The law’s title suggests that the purpose of the repeal is to save funds and avoid duplication of effort. The repeal was effective July 11, 2008.

Health Information

Reporting Children’s Injuries to Law Enforcement

For over thirty years, G.S. 90-21.20 has required physicians and the administrators of health care facilities to make a report to law enforcement when patients are treated for certain injuries that may have been caused by criminal acts. The reporting requirement covers injuries caused by firearms, illnesses from poisoning, and some injuries caused by knives and other sharp instruments. In addition, a report is required for “every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician or surgeon treating the case that the wound, injury or illness resulted from a criminal act of violence.” This last requirement is difficult to interpret, because the terms “grave bodily harm” and “grave illness” are undefined. This difficulty has led to a recurring question: when must physicians and health care facility administrators report to law enforcement any injuries or illnesses that they believe resulted from child abuse?⁷ When is the threshold of “grave bodily harm” or “grave illness” met? In the absence of statutory definitions or court interpretations of the terms, practices regarding reports of children’s injuries to law enforcement have varied.

In 2008 the N.C. Child Fatality Task Force recommended amending G.S. 90-21.20 to clarify this issue. The result was S.L. 2008-179 (H 2338), which adds subsection (c1) to G.S. 90-21.20. The new subsection requires a report to a local law enforcement agency when a child under the age of eighteen is treated for a recurrent illness or serious physical injury that

7. This is a separate issue from whether a child’s injury or illness must be reported to a county department of social services. G.S. 7B-301 requires any person who has cause to suspect a child is abused, neglected, or dependent to make a report to the county department of social services.

appears to the treating physician to be the result of nonaccidental trauma. If the child is treated in a hospital or other medical facility, the report must be made by the facility's director or administrator. Otherwise, the report must be made by the treating physician.

The law specifies that the report to law enforcement must be made in addition to any report that is required under G.S. 7B-301 (reporting of child abuse or neglect to the department of social services). The new reporting requirement became effective December 1, 2008.

Reporting Race and Ethnicity

S.L. 2008-119 (S 4) enacts new G.S. 130A-16, directing medical care providers who make certain reports to the Division of Public Health to include the race and ethnicity of patients in those reports. The term "medical care providers" is undefined, but the Division of Public Health has determined that the new section will apply to reports of emergency department data that certain hospitals are required to make under G.S. 130A-480. The terms "race" and "ethnicity" are also undefined in the new law, but the division plans to use a modified version of definitions supplied in a federal Census Bureau directive. The categories for race are expected to be white, black, American Indian or Alaskan native, Asian or Pacific Islander, and other. The categories for ethnicity are expected to be Hispanic and non-Hispanic.⁸

The same act amends G.S. 131E-214.1 to include race and ethnicity information in the patient data that hospitals and ambulatory surgical facilities are required to submit to a statewide data processor certified by the Division of Health Service Regulation, under the Medical Care Data Act (Article 11A of G.S. Chapter 131E).

The new reporting requirements take effect January 1, 2010.

Anatomical Gifts and Blood Donation

In 2007 the General Assembly repealed North Carolina's Uniform Anatomical Gift Act (former Article 16, Part 3 of G.S. Chapter 130A) and replaced it with the Revised Uniform Anatomical Gift Act (Article 16, Part 3A of G.S. Chapter 130A).⁹ At the same time, the legislature directed the General Statutes Commission to review statutes related to organ donation to determine whether they should be amended to be consistent with the

8. Personal communications with Paul Buescher, Director, State Center for Health Statistics (July 31, 2008 and August 1, 2008) (on file with author). The federal directive mentioned is the U.S. Census Bureau's Directive 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting (May 12, 1977), available online at <http://wonder.cdc.gov/WONDER/help/populations/bridged-race/Directive15.html>.

9. S.L. 2007-538.

revised act. S.L. 2008-153 (S 1651) enacts recommendations arising from that review. The changes to the statutes that resulted became effective August 2, 2008.

Under prior law both G.S. 90-602 and G.S. 130A-412.14 (part of the Revised Uniform Anatomical Gift Act) contained procedures for searching a trauma victim for information about the victim's intentions regarding anatomical gifts. S.L. 2008-153 deletes the search and notification procedures from G.S. 130A-412.14 and replaces them with a provision stating that searches are governed by G.S. 90-602. That statute permits law enforcement and other emergency officials to search individuals who are dead or near death for a document or other information indicating the individual's intention to make or refuse to make an anatomical gift. Hospitals are also permitted to search for such documents if no other source of information is immediately available to them. The statute also allows law enforcement, emergency officials, or hospitals to search Division of Motor Vehicles records to determine whether a trauma victim is a donor of anatomical gifts. The new law amends G.S. 90-602 to specify that law enforcement or emergency officials who locate information about an individual's intention to make or refuse to make an anatomical gift through either of these methods must provide the information to any hospital where the individual is taken.

S.L. 2008-153 further amends G.S. 90-602 to provide immunity from criminal or civil liability to hospitals and persons who fail to discharge their duties under the statute. However, such hospitals or persons may be subject to administrative sanctions. Another amendment provides qualified immunity from civil, criminal, or administrative liability to persons who take (or attempt in good faith to take) the actions authorized by the statute. The new law also incorporates into G.S. 90-602 the Revised Uniform Anatomical Gift Act's definitions of certain terms.

As part of the effort to conform laws relating to the anatomical gifts to the Revised Act, a statute that governed the removal of corneal tissue, G.S. 130A-391, was repealed.

Finally, S.L. 2008-153 amends G.S. 130A-412.31 to change the minimum age for blood donors from seventeen to sixteen; this change became effective August 2, 2008.

Health Professions

Home Care

The term *home care services* is defined broadly in state law to include not only nursing, but also physical, occupational and speech therapy, medical social services, pulmonary rehabilitation, and other services. S.L. 2008-127 (H 964) further expands the definition of home care services to include in-home companion, sitter, and respite care services and homemaker services. The legislation directs the North Carolina

Medical Care Commission to adopt regulations to implement this revised definition, which will go into effect in January of 2010. The legislation also increases the annual licensure fee for home care agencies from \$350 to \$400 beginning in January 2009.

Nursing

The North Carolina Board of Nursing is authorized to establish standards for the faculty of *nursing programs*—educational programs that prepare individuals for licensure as registered or licensed practical nurses.¹⁰ The board establishes these standards through the administrative rule-making process. In May 2007 the board adopted several amendments to 21 N.C.A.C. 36 .0318, the rule that sets the standards for nursing program faculty. The chief effect of the amendments would have been to change the academic qualifications required of faculty who teach in a program leading to initial licensure as a nurse. Presently, such faculty are required to hold either a baccalaureate or master's degree in nursing. The amendments would have required persons employed in that role after December 31, 2014, to hold either a master's or doctoral degree, unless a waiver was granted by the board. The amended rule was approved by the Rules Review Commission in June 2007. The rule, however, was the subject of written objections and therefore was submitted to the General Assembly for its approval, in accordance with the Administrative Procedure Act. S.L. 2008-14 (S 1662) disapproves the amended rule. Thus the academic qualifications for faculty in nursing programs leading to initial licensure are unchanged.

Massage and Bodywork Therapy

Under current law the North Carolina Board of Massage and Bodywork Therapy is responsible for the licensure of massage and bodywork practitioners. S.L. 2008-224 (S 1314) amends the law to authorize the board to approve and regulate massage and bodywork schools. In addition, the law now requires criminal history record checks for each applicant and allows individuals who hold licenses from other jurisdictions to obtain North Carolina licenses in some circumstances.

Studies

The 2008 Studies Act, S.L. 2008-181 (H 2431), authorizes several studies related to health care or public health. It also requires some state agencies to conduct studies related to those areas.

Section 2.12 of the act authorizes the Legislative Research Commission to study the impact of smoking prohibitions on foster care homes. If it conducts the study, the commission must consider whether smoking prohibitions protect the health of foster children or reduce the number of available foster care homes.

Part 3 of the act authorizes the Joint Legislative Health Care Oversight Committee to study the following topics:

- Do Not Resuscitate (DNR) orders issued in the absence of a declaration of a desire for a natural death,
- Regulation of dental laboratories,
- Development of a coordinated statewide electronic health information network,
- Bedding laws (Article 8, Part 8 of G.S. Chapter 130A), and
- Increase in medical records copy fees permitted under G.S. 90-411.

Section 6.7 authorizes the Environmental Review Commission (ERC) to study a date certain for the phase-out of hog lagoons. The ERC is also authorized by section 6.10 to study, in consultation with the N.C. Child Fatality Task Force, a ban on toxic brominated fire retardants.

The Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee is authorized to study whether the prescription drug database maintained by DHHS (concerning prescriptions for controlled substances) should be accessible to county sheriffs and their deputies (Section 8.2).

Part 19 directs the General Statutes Commission to study the Uniform Emergency Volunteer Health Practitioners Act and report its recommendations and legislative proposals to the General Assembly by February 1, 2009.

Part 20 directs the Division of Emergency Management, in consultation with the N.C. Association of County Commissioners, to study and develop plans to enhance emergency management at the county level. The division was to report the results of its study and provide the plans it develops to the Chairs of the Joint Select Committee on Emergency Preparedness and Disaster Management Recovery, the House of Representatives Appropriations Subcommittee, and the Senate Appropriations Committee on Natural and Economic Resources by December 1, 2008.

Part 21 addresses an issue that arose from a recommendation by the UNC Safety Task Force. It directs the Board of Governors of the University of North Carolina, the State Board of Community Colleges, the State Board of Education, and the North Carolina Independent Colleges and Universities to study providing qualified immunity to mental health and health professionals who disclose confidential information for the

10. G.S. 90-171.23(b)(8).

purpose of preventing or mitigating harm to others. In conducting the study the Board of Governors must consult with mental health and health care professionals' licensing boards. A final report, including any legislative recommendations, was to be submitted to the Joint Select Committee on Governmental Immunity by December 1, 2008.

Part 25 directs the State Board of Education to study K–12 physical education in public schools. The board was to report to the Joint Legislative Education Oversight Committee by December 1, 2008.

Part 31 directs the North Carolina Institute of Medicine to convene a panel to study access to appropriate and affordable health care for all North Carolinians and make recommendations. However, in making its recommendations, the Institute may not study issues related to scope of practice or professional licensing. The Institute must report its recommendations to the Joint Legislative Health Care Oversight Committee by January 15, 2009.

Part 34 ensures the continuation of the Joint Legislative Study Committee on Emergency Preparedness and Disaster Management Recovery. Section 34.1 establishes the committee and provides for the appointment of its thirty members. Section 34.2 directs the committee to study a number of issues, including North Carolina's public health infrastructure and its capacity to respond to disasters, including pandemic flu; and bioterrorism preparedness and response. The committee must submit a final report to the General Assembly by December 31, 2009. The committee terminates upon submission of its final report.

Part 47 creates the Epilepsy Patients and Medication Interchange Study Commission, a twenty-one-member body charged with studying the protection of epilepsy patients from medication interchange. The commission must report its findings and recommendations to the General Assembly and the Joint Legislative Health Care Oversight Committee by February 1, 2009. The commission terminates upon submission of its final report.

Other Laws of Interest

The following laws, which may be of interest to readers of this chapter, are summarized in other chapters of *North Carolina Legislation 2008*:

- S.L. 2008-2 (S 1480), providing for medical releases from custody for certain prisoners who are disabled, terminally ill, or aged and incapacitated by illness, is summarized in Chapter 23, "Sentencing, Corrections, Prisons, and Jails."
- S.L. 2008-136 (H 1134), authorizing counties to adopt and implement a plan for the management of abandoned manufactured homes, is summarized in Chapter 4, "Community Planning, Land Development, and Related Topics," Chapter 7, "Economic and Community Development," and Chapter 11, "Environment and Natural Resources."
- S.L. 2008-170 (H 1113), limiting the use of the public duty doctrine as an affirmative defense, is summarized in Chapter 14, "Local Government and Local Finance."
- S.L. 2008-191 (S 1860), implementing recommendations of the N.C. Child Fatality Task Force to increase the penalty for misdemeanor child abuse and amend the offense of felony child abuse, is summarized in Chapter 6, "Criminal Law and Procedure."
- S.L. 2008-200 (S 1766), providing qualified immunity from liability for certain private entities that assist government officials in responding to emergencies, potentially including public health emergencies, is summarized in Chapter 10, "Emergency Management."

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